

DYSFUNCTIONAL ISOLATION IN THE ELDERLY: INCREASING MARITAL AND FAMILY CLOSENESS THROUGH IMPROVED COMMUNICATION

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ABSTRACT: Unique developmental crises in old age may lead to social withdrawal that negatively affects the individual and his/her marital and family relationships. Without an awareness of these aging dynamics, the therapist can inadvertently perpetuate these distancing behaviors which can exacerbate marital and family conflict. This paper discusses certain developmental crises which can result in increased isolation for the older adult, and suggests therapeutic interventions to facilitate increased closeness among family members.

Even though older adults comprise a significant portion of the population, little attention has been directed to the mental health needs of this group, particularly as they relate to their marriage and family lives. Marital and family concerns of the elderly have not been considered significant largely because of overriding stereotypes. For example, many people believe the myth that all of today's elderly are abandoned or ignored by their children (McGoldrick & Carter, 1980;

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Zarit, 1980). Actually family relationships continue to be important through late life. Among the current generation of elderly, the overwhelming majority who were married have one or more children with whom they interact frequently (Troll, Miller, & Atchley, 1979). Marital happiness at this stage of life is equally as important (Anderson, Russell, & Schumm, 1983). There are also many developmental transitions such as retirement and widowhood that require family support at this stage of life.

Most literature discussing family intervention for the elderly has been limited to issues of institutionalization (Brody & Spark, 1966; Cath, 1972; Miller & Harris, 1967) and death and loss (Berezin, 1980). It is only recently that gerontologists (e.g., Gurian, 1975; Miller, Bernstein, & Sharkey, 1985; Savitsky & Sharkey, 1972) have elaborated on family systems theory to explain a variety of medical and/or psychiatric symptoms that may be family related. Still, there are few articles dealing with marital and family problems of the aged. Miscommunication, for example, is a central element of marital and family problems for the elderly, as it is for the young. Miscommunication, however, is triggered by different developmental events occurring throughout the lifespan.

There are many characteristic physiological, psychological, and social processes that can accompany old age and, when misread by family and friends, can induce isolation at a time that one's spouse and family are greatly needed. Without understanding the dynamics of aging, a therapist may perpetuate increased withdrawal and assume it is the elder's willful choice. We shall consider physiological, psychological, and social isolations among the elderly and then look at a strategy of intervention appropriate to the condition.

PHYSIOLOGICAL PROCESSES

Biophysical decline occurs with old age and can act as a physical isolator. For example, limitations in physical mobility, sensory losses, diminishing physical vigor and endurance, changes in physical appearance and symptoms of specific diseases can all alter, reduce, or prevent social participation. Sensory losses influence the elder's ability to communicate fully. Cognitive losses associated with organic brain syndrome often lessen interaction skills, sometimes to a point where it is impossible for the elderly to have meaningful interaction with friends and family. Presbycusis (hearing loss) and Alzheimers

disease (cognitive dysfunction) will be examined below since their effects on communication are among the least understood and most incapacitating, particularly with regard to marital and family relationships.

Presbycusis

Presbycusis is one of the most widespread sensory deficits associated with the normal aging process (Hull, 1978). In both men and women hearing sensitivity decreases and the prevalence of deafness increases with advancing age. Between ages 55 and 75 the incidence of deafness rises from about 2.8% to well over 15% (Rockstein & Sussman, 1979). Up to 50% of the elderly 65 years and older experience a hearing deficit severe enough to require a hearing aid (Stevens, 1982). However, little systematic research has been conducted on the effect of hearing loss on the quality of their interactions.

The hearing of high frequencies is affected first and most severely. This interferes with hearing high pitched sounds such as a ringing telephone, doorbell, high-pitched female voices and some sounds of the alphabet (s, sh, ch). As the condition progresses, the middle frequencies, which contain most of the sounds of speech become affected; finally, so do the lower frequencies. As a result, speech may be heard in a distorted or even unintelligible manner. The elderly individual suffering from presbycusis will usually know when he or she is being spoken to, but may not always understand what is being said. Since the words are distorted, comprehension requires tremendous conscious effort (Price, Snider, & Reichel, 1983). Of course, in some cases the hearing loss can be so severe that the individual may not be able to acknowledge the sound at all.

The distortion of sounds that comes with presbycusis prevents the successful use of hearing aids among many hearing impaired elderly. Hearing aids only make sound louder. Therefore, what takes place is simply the amplification of distorted sounds. The hard of hearing individual will continue to have communication problems even when wearing an optimally performing hearing aid (Sanders, 1975).

Perhaps the most difficult problem facing the presbycusis individual is in understanding speech in the presence of background noise (Nadell, 1979). The presbycusis will more than likely need to be face to face for conversation and will rely heavily upon lip reading. Rockstein and Sussman (1979) point out that this means of communi-

cation will be difficult or impossible for an older person who is likely to be suffering from visual impairments as well. The elderly with hearing problems are often unable to judge how loudly they themselves are speaking and may actually shout without realizing it. Because they are not able to monitor their own speech, they may begin to slur their words.

Impaired hearing often changes one's interpersonal interactions with one's family and spouse. The inability to discriminate what one hears causes many "Whats" and "Huhs" to be extended. This causes frustration for both parties: The first party may feel as though the hearing impaired person is simply not listening. The hearing impaired individual may think that the speaker is purposively talking "too soft" or slurring his or her words intentionally. Over time, these two individuals will communicate less frequently. This same scene is then replayed with other family members and friends; eventually the hearing impaired person and his/her family significantly may reduce all interpersonal involvement.

In addition, the hearing impaired person begins raising his/her voice because of the inability to monitor its loudness. This appears to the family as "shouting" and is associated with anger. Family members may in turn respond to the hearing impaired individual with anger and sharp accusations of "stop shouting at me." Confusion and misunderstanding result for both parties.

These interpersonal interactions are further complicated by the fact that often the impaired individual and his/her family are unaware that hearing impairment is involved. Presbycusis is a slow deterioration of the inner ear which often goes unnoticed for years. The hearing impaired person develops compensating behaviors over the years (e.g., more reading or TV watching and less talking) to which the family responds with incorrect assumptions. For example, "Dad turns the TV up loud because he doesn't want to be bothered . . ." "My husband doesn't listen to me the way he used to. I know it's because he doesn't love me anymore." Such attributions involve perceiving Dad as willfully distancing. Meanwhile, Dad feels as though his family is not interested in him because they are always whispering. They seem to avoid having discussions with him. He attributes their behavior to intentionally rebuffing or ignoring him. To the unskilled eye, this may appear so. However, this family may be asking for and need more closeness, not distance, to reestablish a healthy balance that has been uprooted by Dad's retreat into isolation. Simply discovering the hearing impairment will not necessarily

solve the problem. A hearing aid cannot correct distortion problems. Unless other changes are instituted, the same family dynamics will likely remain.

Alzheimers Disease

This malady has only recently received attention and is associated with symptoms of memory loss and the loss of thinking and reasoning capacity. Alzheimers disease appears to be the most frequent cause of irreversible dementia in adults. It has been estimated that between 50 and 60% of cases of dementia have brain pathologies characteristic of Alzheimers disease (Roth, 1980). The intellectual impairment progresses gradually from forgetfulness to total disability.

Alzheimers disease, like presbycusis, often goes undiagnosed initially. Early memory problems are sometimes mistaken for stress, depression, or even mental illness. Also, Alzheimers disease may go unnoticed because of the myth of senility—everyone experiences forgetfulness as they get older. However, severe memory loss is never a normal part of growing older. Mace and Rabins (1981) indicate that five percent of the elderly population suffer from a severe intellectual impairment and approximately the same percentage from milder impairment. Some Alzheimer victims also experience changes in their personalities which are confusing to family members. This creates potential stress and miscommunication.

The Alzheimer family member may experience expressive and/or receptive communication difficulties. Mental voids create problems in retrieving words. In order to express oneself, the individual may substitute similar sounding words such as “wrong” for “ring” or may simply describe the word for “ring” as “a thing that is round” (Mace & Rabins, 1981). As the disease increases in severity, the individual may only have a few words remaining in his/her vocabulary. Receptive communication problems involve being able to read without understanding what is being read. Another problem is having the ability to understand conversation in person but not over the telephone.

These communication difficulties can cause other people to remain at a distance, communicating with the Alzheimer patient less and less frequently. However, this contact with others is needed to prevent both physical and emotional isolation. In addition, around-the-clock caretaking is often needed, a factor which often isolates the caretaker from friends and activities. The literature discussing Alz-

heimer disease consistently points to a need for the caretaker to maintain a social life (McDowell, 1980; Zarit, Orr, & Zarit, 1985).

PSYCHOLOGICAL PROCESSES

Depression

The most prevalent psychological problem of older persons is depression (Epstein, 1976; Garland, 1976; Zarit, 1980). Seligman (1975) maintains that a "learned helplessness" exists among depressed older people. This is not surprising, in that "loss" is a common theme in old age (e.g. financial, personal, and physiological loss). The older person feels increasingly helpless in controlling his/her health and the impending death of self and spouse. Many researchers (Beck, 1976; Kahn, Zarit, Hilbert & Niederehe, 1975) have also discussed the cognitive aspects of depression. Some older people come to view themselves in negatively stereotypic ways and become overly pessimistic about their abilities and self-worth.

Depression is also discussed as a consequence of "learned" behavior based on the reinforcement patterns of family and spouse (Rimm & Masters, 1974). In a setting where the family only pays attention when the elderly member is showing signs of depression ("Nobody cares if I live or die"), the family may be inadvertently reinforcing the depression.

One difference between a depressed person and nondepressed person involves isolation. The depressed person engages in fewer activities and finds fewer activities enjoyable. Such behavior only feeds the depression. The depressed elderly individual is in need of family involvement and support.

SOCIAL PROCESSES

Over the course of the life cycle, a person typically experiences changes in norms, expectations, social status, and social roles. Other's reactions to the older person are based in part on these changes. Ageism also stigmatizes the elderly as uninteresting and having little to contribute to others. If the elderly believe this, particularly, at a time in life when one's social connections diminish due to events such as retirement and widowhood, then it may be difficult to find a reason for getting involved in life. This may lead to isolation.

Once again, this increased distance from others may be viewed by a therapist as a normal developmental response when in actuality more opportunity for interaction with family and friends would provide more life satisfaction. This is not to discount the literature (Maas & Kuypers, 1974; Neugarten, 1977) that points to disengagement as a willful and fulfilling choice by many. It is the "willful choice" that needs to be evaluated in terms of accuracy.

Retirement

Retirement can pose a stressful time for couples. Before retirement, each partner may have maintained separate spheres of influence and activity from which they derived satisfaction, meaning, and self-esteem. Clear boundaries existed. Retirement creates a different couple structure, and these boundaries may become blurred. Minimal research has focused on an integrative approach that considers the employment status and retirement of both spouses (Kelly, 1981; Ward, 1984).

There is even less information concerning adjustment among female retirees. This is an important research focus because it has been indicated that both the subjective experience and objective conditions of retirement differ for men and women (Szinovacz, 1986). In addition, a cross-national study (Pampel & Park, 1986) reveals differences among retired women related to economic and social characteristics. However, as it currently stands, most of the literature investigating retirement issues has focused on how women have responded to their husband's retirement. There have been frequent complaints from housewives about their husband's interference with household tasks (Darnley, 1975; Fengler, 1975). For example, lower-class wives report being dissatisfied with their husband's participation in household roles and complain about "having them underfoot," whereas middle-class retired couples agree on joint household duties but disagree on how the tasks are to be performed (Maas & Kuypers, 1974; Keating & Cole, 1980; Szinovacz, 1980).

Another potential obstacle to retirement adjustment is the restructuring of time. Many retired find it hard to develop a new routine, complain about wasting their time, and express feelings of boredom and uselessness (Szinovacz, 1978; 1980). This can place stress on the marital relationship.

Successfully retired couples are able to merge their territory and interests and derive new boundaries and structure. At this time in life, the older couple values companionship, mutual understandings,

and expressiveness as necessary conditions for marital satisfaction (Darnley, 1975; Roberts & Roberts, 1980). Isolating behaviors, of course, work against the achievement of marital intimacy. This is particularly true for couples who spent little time together before retirement. For such couples, retirement can be an awkward and tense time.

Widowhood

The loss of one's companion can be devastating to one's view of reality. The initial sense of loss, disorientation, and loneliness experienced by the survivor contribute to the increase in death and suicide rates in the first year, especially among men (McGoldrick & Carter, 1982). Survivors may also respond by withdrawing from others. Widowers are more apt to isolate themselves since it is usually the wife who links the husband to family and social involvement. It is important to understand these dynamics in order to therapeutically implement strategies for facilitating family support and interpersonal closeness after the loss of a spouse.

INTERVENTION

It is a common belief that families in later life are too set in their ways to change long-standing interactional patterns. This myth is slowly fading, since the elderly do indeed possess the ability to change. However, because of unique developmental milestones in old age, the therapist must consider appropriate ways to help the elderly facilitate change. It may be inappropriate and perhaps damaging to unquestioningly employ with the aged certain existing therapeutic models developed for use with families with school age children (e.g., "functional family therapy," Alexander & Parsons, 1982; Barton & Alexander, 1981). Without an understanding of aging dynamics, the therapist may support some behaviors inappropriately and inadvertently exacerbate the problem.

We will describe several procedures for increasing the quality and quantity of communication between the aging individual and his/her family members. Many of our suggestions are startlingly straightforward, yet each can have dramatic results. Each intervention focuses on obvious and accessible verbal and nonverbal behaviors. By focusing on behaviors, the therapist is able to minimize the

influence of social stereotypes and myths about aging and deal with what is or is not helping within the family. Zarit (1980) states that the direct and problem-oriented style of behavioral therapy makes it the most appropriate way of working with the elderly. It is to be hoped by pinpointing the cues that elicit particular distancing responses, the therapist can teach members to replace these cues with more appropriate responses that elicit positive feedback and increased family intimacy for the aging individual.

Physiological

There are some simple but important communication practices that the therapist can teach the family about interacting with their hearing impaired loved one. For example, it is important to give the impaired person as many clues as possible for discriminating what is being said. The speaker should avoid covering his/her mouth when speaking and should maintain relatively close face-to-face contact. Moreover, the speaker should enunciate clearly and keep background noise to a minimum. Gestures can also help supplement speech at times (e.g., pointing to one's wrist when asking for the time).

Intense feelings of suspicion are common by-products of presbycusis and often causes the individual to retreat into isolation. An illustrative cycle of family interaction that generates suspicion is as follows: Father is reading the paper in the living room while Mother and the two daughters are talking in the adjoining dining room. They are speaking at normal levels but Father can only periodically hear a few words which are followed by laughter. Father asks, "What are you laughing about?" Mother responds very innocently with "Nothing." This puzzles Father. He knows that they are laughing about something. He is further annoyed that they appeared to be whispering. Over time, he becomes convinced that they are intentionally speaking in low voices because they are trying to hide something from him. He also becomes suspicious that any laughter is about him. He may initially become hostile and angrily challenge his family with "If you have something to say about me, say it to my face" or "What's so damn funny?" This causes the family to avoid talking when Father is in sight. This only reinforces Father's paranoia—"Why is everyone being so quiet? What are they hiding?" Father eventually realizes that the best way to cope is to avoid interaction and to retreat into isolation.

What can a therapist suggest to break this negative cycle? The

cue that elicited the cycle of suspicion and withdrawal from family members was that of perceived whispering. Father, for one, can be taught ways to break this cycle, such as becoming more specific and direct in his own communication. For example:

Father: I only caught the words “dog” and “hamburger.”
Would you repeat what you just said because it sounds awfully funny?

This indicates to the family that Father is really interested in their conversation. Family members are more apt to respond favorably since the exchange was pleasant. Another option is for Father to learn to move to where the family members are and say: “Could you please speak a little louder and slower? I’d like to hear about Aunt Helen.” It is important that the hearing impaired person also take responsibility for creating a conducive hearing environment. A reminder to the family members is simply a courtesy—a verbal cue about the impaired individual’s situation. A particular gesture from Father, like a wink or hand on his ear, could be selected as a reminder to family members when they are speaking too softly. A designated gesture is particularly useful in public, when the individual does not wish to call attention to the hearing impairment.

Family members can also learn ways to break the above cycle when they first note Father’s anger. For example:

Father: (Angrily) What are you laughing about?
Mother: About Aunt Helen who sat on the stove.
Father: Oh.
Mother: Would you like to know more about the incident?
Father: No (calmly).

Family members should always try to answer fully the hearing impaired person’s question. This has two advantages. First, it dismisses the individual’s fear that he/she is being talked about. Second, it provides the individual with a choice of whether or not to pursue the topic in question. This provides a therapeutic sense of control which makes it less likely that the hearing impaired person will angrily withdraw.

Family members may feel annoyed when the hearing impaired person continually responds with “What” or “Huh” because they believe that he or she is intentionally not “listening.” It is the attribution of “not listening” that is detrimental to relationships. The per-

ceived "not listening" behavior is associated with "not caring" which causes the recipients to eventually decrease their amount of interaction with the hearing impaired individual. Therapists can encourage alternative responses that give the speaker a sense of being listened to. More appropriate responses from the impaired individual could include: "You said you were going where at what time?" or "I heard you mention your brother's name but I missed the rest of the sentence."

Because hearing impaired individuals are unable to monitor their speech, they often speak loudly. This frequently elicits "staring" behavior or laughter from onlookers in public. In the home, it can be annoying to family members. Again, cues should be developed by family members to alert the individual of his/her increased loudness. And when the hearing impaired individual responds with frustration at the reminder, it is helpful for family members to return caring responses such as: "I understand why it frustrates you when I remind you of talking too loudly. Please, remember to remind me when I'm talking too softly."

Alzheimers Disease

In order to avoid making the Alzheimers victim feel isolated, there are again basic communication procedures a therapist can teach family members. It is important to talk regularly with the Alzheimer member, particularly if he/she is only mildly to moderately impaired. Even though communication can be difficult, it is important to not display frustration. Talking calmly will less likely ignite any catastrophic reactions that are common among individuals with this disease. Of equal importance is for family members to avoid talking about the impaired person to others in front of him/her. This only contributes to the frustration felt by the Alzheimer victim.

As mentioned previously, catastrophic reactions are very common among individuals with Alzheimer disease and can be one of the most difficult problems for the caretaker. These reactions are often caused by having to think about several things at once. One useful therapeutic procedure is to teach the caregiver effective instruction-giving (Mace & Rabins, 1981). This means breaking down tasks into step-by-step instructions such as: "I'm going to seat you in the chair. I'm going to put the spoon in your hand. Put the spoon in the corn. Bring the food up to your mouth." During this process, it's important to constantly reassure the individual "That's O.K. It's near the corn. Try again. Push the spoon this way. Good!" This approach will, it is

hoped, keep the impaired family member from responding with frustration by having to “remember” the sequence of events.

There are various communication approaches to assist the Alzheimer victim with any expressive or receptive difficulties. Family members can help the Alzheimer victim with expressive obstacles by helping to supply the word for the individual rather than allowing him/her to search and struggle. When the wrong word is used, supply the right word. Only avoid doing this if the individual indicates that it upsets him/her. It is often helpful to ask the impaired individual to describe the unintelligible word or point to it. A verbal response of “what” is more likely to elicit frustration (Mace & Rabins, 1981).

Victim: I like your hurt.

Caretaker: Describe a hurt.

Victim: A thing that keeps out rain.

Caretaker: Point to it . . . oh yes, my hat. Thank you.

Non-verbal behaviors are a valuable communication tool in breaking through receptive difficulties experienced by the impaired family member. For example, sitting an Alzheimers victim on the bed and closing your eyes may be a helpful clue for “bedtime.” A hug, pat, or kiss are potent messages of love and caring.

Depression

Depressed persons manifest fewer social skills that elicit positive reinforcement from others (Zarit, 1980). They are also more vulnerable to life changes that alter the amount of positive reinforcement they receive because they have fewer skills for developing new sources of stimulation and reward.

When working with an elderly family member displaying “distancing” behaviors related to depression, a therapist should model and provide opportunities for the behavioral rehearsal of new, more appropriate communication skills. In addition, family members can learn alternative ways to respond to the depressed, distancing elderly family member. For example, a predictable cycle when an elderly family member says “Nobody cares if I live or die” might be for family members to respond with a series of emotional responses: “What do you mean? Of course we care very much about you! Please don’t talk that way!” Such interchanges can increase to the point where such depressive statements become the only way for the older person

to elicit concern. Such responses can become habitual in that they are reinforced by family members' reactions. Eventually, they push family members farther and farther away.

A brief, caring comment that acknowledges the older individual's concern but does not elaborate on the issue may be less reinforcing. Family members can also practice rehearsing communication that reinforces the older family member's positive behaviors and integrates them into their daily life. For example:

Grandma, I need to make cookies for my girl scout meeting and since you make the best oatmeal cookies, I thought you'd like to show me your recipe.

Grandma, you are so creative. Could you help me think of a charitable project for my running club?

Mom, you've had much more experience at raising children. Could you give me some ideas for how to keep my five year-old quiet during Sunday school class?

These comments not only recognize the positive contributions the elderly member can make but also search for pleasurable activities in which to engage the member.

Social Aging

Potential social crises accompanying old age, such as the previously discussed events of retirement and widowhood, are excellent times for therapy focusing on the reshaping of communication skills. Such events often restructure the lives of elderly individuals so that old patterns of interaction no longer fit. For example, little time is spent renegotiating their new routine expectations around the home. Conflict can occur from a miscommunication of these expectations and cause a distancing process. It is often helpful for the couple to discuss the meaning of these distancing cues. The communication approach that is the most helpful is using the word "I" to discuss their own feelings. For example:

Retired spouse: My daily schedule has changed over night and I am at a loss as to what to do.

Non-retired spouse: I feel cheated that you have your days free and my duties here at home remain the same. I always thought that we were both going to have it easier one day.

Retired spouse: I can understand what you're saying. I just

don't know what you expect me to do around the house. I wouldn't know where to begin on my own.

During the couple's exchange of feelings, the therapist is actively involved in helping the couple to keep the communication in the "I" format. The therapist can guide the communication process to the point where the couple are ready to negotiate the new roles in the home. Continuing reframing can be used to identify the noninvolved role in home chores as one of confusion rather than noncaring.

In addition, any retirement maladjustment such as feelings of boredom and uselessness may manifest itself through depressed behaviors. This could be misinterpreted as aloofness and disenchantment with the marriage. The same communication skills can be incorporated to assist the couple:

Nonretired spouse: I'm feeling very lonely since you retired. You lock yourself in your study all day. I feel as though you are trying to hide from me.

Retired spouse: I can't explain it, but I'm feeling lonely too. I'm so used to getting up and being in the office and now I'm not sure where to go or what to do. It hasn't anything to do with you. I'm just feeling like I don't have a purpose each day.

Again, the therapist can guide the couple toward creating a new structure by helping them get involved in new activities:

Therapist: Are there any activities you've wanted to participate in but didn't have the time when you were working?

Nonretired: My wife and I have mentioned several times about how we would like to breed and train Golden Retrievers. Maybe we should go to the club meeting this month?

Retired: That's true. Sounds like a good idea.

Widowhood is another developmental crisis that can cause distancing from one's family. Again, a grieving process accompanies this life transition and varies among individuals. The therapist should help family members realize that distancing behaviors at this time should serve as cues for them to communicate in understanding and caring ways:

Family Member: I can understand that you're not feeling like socializing at the family reunion. You've always at-

tended with grandpa and it must be lonely not having him here now. I want you to know that you're very important to me. If you change your mind about attending, call me at home. I know that I can't replace grandpa but I'd love to take you. And if you decide not to come, I'll still give you a call that evening.

Death is an uncomfortable issue for many people. Increased feelings of isolation can occur in a spouse when others ignore the topic of his/her loss. It is usually best for the therapist to help family members acknowledge the deceased individual and provide the survivors with opportunities to discuss their feelings.

CONCLUSION

The challenges accompanying the later stages of life are largely uncharted and without precedent. Elderly individuals and their family members do not know what to expect. No one has prepared them for how to deal with the lengthy lifespan beyond retirement or the confusion induced by presbycusis or Alzheimers disease.

Indeed, many unique physiological, psychological, and social developments occur in later life which can create distancing behaviors that are not necessarily the intent of the individual. If misread by a therapist, one's spouse or family, this distancing can be perpetuated and negatively affect interpersonal relationships. We have attempted to pinpoint particular developmental crises that can create unwanted distancing behaviors. Cues that elicit particular distancing responses have been identified and alternative responses to elicit more positive interactions have been provided. It is our hope that, through such interventions, opportunities will be expanded for older individuals to receive the nurturance and family support they deserve in their later years.

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