Forming a Therapeutic Alliance With Older Adults

By: Celia R. Hooper

Hooper, C.R. (1996). Forming a therapeutic alliance with older adults. *American Speech-Language-Hearing Association*, 38, 43-45.

*****Note: Figures may be missing from this format of the document**

"If you want to help me, help my family."
—*stroke patient*

Speech-language pathologists and audiologists are well aware that older people constitute our fastest growing patient population. Adults over 85 are appearing more frequently in clinician caseloads. This increase reflects demographic changes, with the typical older patient being female and widowed, living alone with multiple health problems, taking an average of seven prescription medications, and needing health and social services. According to the 1983 Current Population Survey, older men are three times more likely to be married than older women, and older women spend twice as long living alone in widowhood as older men. These data affect caregiving when health problems occur: who gives care, how much family help is needed, and what forms that help may take.

What is Family?

Families provide most support for older relatives who are sick, with spouses providing most support, daughters next, and other relatives, friends, and neighbors third. But what is "family"? "Primary kin" is a term used to describe the most likely relatives: spouse, children, and siblings. "Secondary kin" can describe others who may function as family, such as friends and neighbors. Sometimes called "fictive kin," these individuals may provide as much, or more, quality of life and happiness for the older adult as the primary kin. They often provide support in tandem with other family members.

Who Is Family?

Rehabilitation professionals should care about who constitutes the older adult's "family." First, they need to know which family member is communicating the most with the older patient. Second, they need to know which family member is bringing the most pleasure and help to the life of the older patient. In any helping relationship, the clinician enters a therapeutic relationship with the patient. This relationship, recognized in mental health professions as a treatment outcome variable, evolves over time. Some suggest that a therapeutic relationship can be formed with other caregivers.

How can the clinician find out who might compose a therapeutic alliance? An "eco-map" can help. Older adults and / or their family member(s) draw circles to represent all of the persons and organizations, such as friends, bridge club, church, health clinic, and so forth, that are part of their life. These circles are connected with coded lines to reflect the nature of the relationship. The clinician can thus learn about the patient's complex social networks. The actual drawing of

the eco-map can be used as a language or memory task, and can even enhance the therapeutic relationship. The eco-map can be adapted for a "family communication diagram" in which older adults and / or their family members draw circles to represent those with whom they communicate. The patient answers a series of questions about the forms this communication takes (letters, conversations, visits, etc.) and how much they add to the patient's quality of life. One family member may visit an older adult in an institution and bring pajamas. Another may write and discuss thoughts, hopes, dreams. Each form of communication brings different sources of satisfaction for the patient/ therapeutic alliance.

Activities such as the above assist in discovering which family member brings the most pleasure or adds most to the quality of life of the older patient. Patients who are adequate communicators may themselves reveal this information. Sometimes the family as a group is aware of certain persons who are most important, such as a particular son or daughter who can "always get grandpa to wear his hearing aid."

It is beneficial to know who is communicating with the older adult and at what level of satisfaction. This person(s) can affect the older patient's

- level of depression
- attempts to communicate
- motivation to continue communicating
- motivation to "practice"

Why write letters if you have no one to write to or no message to take? Why practice word finding if no one talks to you? Why practice walking if you have nowhere to go? Why learn to make a telephone call if you have no one to call? Why wear a hearing aid and learn to improve speechreading if your children never listen?

Improving Outcome

Family caregivers, in cooperation with the speech-language pathologist or audiologist, can improve rehabilitation outcome by translating information to the older patient. In my own clinical practice, notebooks of information are used with family members for various disorders (aphasia, dementia, dysphagia) and coded for level of information. They are loaned to family members, discussed in family meetings, and translated for the patient if needed. Patients and their families are encouraged to tape-record sessions with speech-language pathologists, audiologists, or other professionals. This helps the family keep a record of what is often explained during stress. Taping may help the older patient, who processes information at a slower rate because of hearing loss or speech /language processing differences.

Family caregivers, with support from the rehabilitation team, can extend support to the older patient. This support can take many forms, including problem solving, encouraging treatment adherence, and providing emotional support. We are not just being "nice" when we help families; we are aiding treatment outcome and saving medical dollars. Research from a Veterans Administration Medical Center cooperative study of family interaction and treatment adherence after stroke indicates that better- functioning families (defined by better problem solving, communication, and affective involvement skills) adhere better to the treatment protocol. In

another investigation, using the Family Assessment Device and clinical data, it was found that family function is a better predictor of hospital stay than baseline ratings of typical predictors of stroke outcome. Family function is critical to an effective, cost-saving, health care delivery system.

The therapeutic alliance can help everyone adjust to the recurring sense of loss in the family system. Speech-language pathologists and audiologists should listen when family members and older patients have the need to tell "what grandma was like before." This process can be aided by using photographs, pictures, stories, videos, and other memorabilia from a past work or home life. It's often therapeutic to use these items in treatment. On the other hand, the rehabilitation professional may be one of the first to know the older patient as he or she is in the present. The family may find great solace in learning that the older adult can relate and function in a new way with new people, even if in a diminished or different capacity.

Better Communication

The rehabilitation professional needs to understand four important concepts:

- differences in belief systems as they relate to illness
- differences in views of power and control in the health care arena
- differences in "the life world" and "the medical world"
- differences in professional, family, and patient communication style and abilities.

Older adults may have different belief systems about problems and solutions as they relate to illness. For example, the older adult patient may believe a stroke is "God's punishment" (moral model); the adult child may believe that the stroke was a random event related to the father's arteries (medical model); the angry wife may consider the stroke the fault of the husband who did not take his medication (another form of the moral model).

Members of the therapeutic alliance need to examine their views of power and control in a relationship that may include an older adult who tends to be more dependent in the health care arena. A delicate balance may be difficult if the (usually) younger professional fails to examine stereotypical beliefs about age, job responsibility, or power, and the adult children fail to examine possible problems in role reversal.

Illness is also a cultural experience. One is immersed in the "medical world" as opposed to the "everyday life world." Professionals need to strengthen the connections between these two worlds by explaining differences, better understanding the patient's life world, or questioning practices in the medical world as they relate to functional communication.
Lastly, more effective communication can take place when speech-language pathologists and audiologists use their skills to improve communication. They can help patients adjust to sensory loss through adaptive personal or home equipment. They can help family members and caregivers gain insight into their own communication style through the use of gerontology or communication questionnaires, videotaped analysis, or modeling in treatment or support groups-all to enhance a positive therapeutic alliance.

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