Effective communication with families can improve clinical process and outcomes in long-term care. Such communication may be challenging to long-term care clinicians, who may feel they lack requisite skills or are uncomfortable with potentially charged and negative emotions that may result. These barriers can be overcome by using models of family behavior and of physician involvement in family counseling to foster understanding and organize family meetings. We present such models in this article. The first of these, the Pearlin Stress Process Model offers a framework for understanding family adaptation to long-term care. Within the Pearlin model, family function is a critical intervening variable. Structural Family Systems Theory is therefore examined next to guide to recognition of family characteristics that impact communication. We focus on translation of these theories to long-term care practice through clinical case vignettes. Applying the Levels of Physician Involvement in family oriented care to long-term care, we then suggest an organizing, stepwise process for the family meeting itself. We conclude with strategies for conflict management and a discussion of the importance of the interdisciplinary team in family care. (J Am Med Dir Assoc 2007; 8: 265–270)

Keywords Family systems; communication; long-term care; professional-family relations

Case 1: An 85-year-old woman was admitted to a nursing home for rehabilitation status after a fall and repair of a hip fracture. She also suffered from moderate Alzheimer’s, renal failure, hypertension, and multiple falls. Before the hip fracture her daughter single-handedly provided at-home care for the preceding several years. The daughter was tearful at the time of admission and had some feelings of guilt at having had to “put her mother in an institution.” A couple of weeks later, the attending physician was surprised to receive a carefully handwritten note on monographed stationary from the daughter. The note apologized for being “too emotional” and expressed hope that this would not affect his willingness to care for her mother. The attending immediately called the daughter to reassure her that her feelings were neither excessive nor inappropriate and in no way prejudiced her mother’s care. Subsequently, he urged the daughter to attend the facility’s family support group. At his suggestion, she entered individualized counseling.

This vignette highlights the stress family members experience before and during the long-term care process. As in the daughter described here, stress levels can lead to distortions and self-blame that approach clinical thresholds for anxiety or depression. Thus, the long-term care clinician is faced with 2 patients, the individual elder and his or her family. Although we as medical directors and attendings of necessity must focus on the patient, families also need our help for support, information, self-care, and guidance.

Winn et al 1 discuss working with families as part of their overarching review of communications issues in long-term care, which also addresses physician-nurse communication and the role of the medical director in enhancing communication. They underscore the importance of family communication, as summarized in Table 1, and offer pragmatically based communication suggestions with attention to end-of-life care.

The current article builds on and extends this foundation with a specific focus on communication with families. Here, we relate communication suggestions to theories explaining family behavior and physician involvement in family coun-
Table 1.  Reasons for Working With Families

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<th>Reason for Working With Families</th>
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<tr>
<td>Obtain collateral history</td>
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<tr>
<td>Clarify the nature and goals of long-term care</td>
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<tr>
<td>Clarify resident/family choices for care</td>
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<tr>
<td>Promote trust and build relationships</td>
</tr>
<tr>
<td>Reduce liability, risk management</td>
</tr>
<tr>
<td>Reduce distress, facilitate adjustment</td>
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<tr>
<td>Understand and predict family behavior</td>
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The theoretical perspectives offer several advantages. They provide an organizational framework that facilitates recall and understanding. They can also help long-term care clinicians to predict family behavior more readily, and match communication strategies accordingly. In addition, they offer a structure for organizing family meetings. Our specific objectives in this article are, first, to review the elements of the Stress Process Model and Family Systems Theory germane to long-term care, using case-vignettes to illustrate how these theoretical underpinnings can inform communication. Second, we discuss how the Levels of Physician Involvement Model can be used to plan and conduct a family meeting.

MODELS FOR UNDERSTANDING FAMILIES IN LONG-TERM CARE

Our empirical database for understanding of families in long-term care is limited. Most research is of recent vintage and constrained by limitations such as cross-sectional designs, small samples, lack of sociodemographic diversity in study samples, and quantitative approaches to a phenomenon that lends itself to qualitative study. Martire et al3 point out that study of family involvement in chronic illness and long-term care is in need of conceptual models to organize thinking and inform clinical approaches. These models are reviewed below.

Stress Process Model

Arrival in a long-term care setting can be a source of family stress characterized by high emotional intensity, with feelings of guilt, anger, fear, and distrust. In addition, families may not understand the nature of long-term care, its goals, strengths, or limitations, further intensifying negative emotions. Additional stressors include disagreements about treatment goals, disapproval of other members’ actions or attitudes toward the patient, and perceived inequity in burden-sharing.4 The stress of long-term care placement may also activate preexisting family conflicts and dysfunction, which may pose an additional barrier to effective communication. Understanding family stress thus is central to optimizing communication.

Pearlin et al5 developed the Stress Process Model as a means of understanding burden and adaptation in the face of being a caregiver for a person with dementia. As shown in Figure 1, the model postulates that family members experience primary objective stressors (the “hands-on” demands of caregiving) and primary subjective stressors (the emotional response to these demands and the effects of caregiving on job, finances, and other social roles).

These stressors are modified by background and demographic attributes and by coping resources to produce outcomes such as satisfaction/dissatisfaction with long-term care. Such coping resources may include facility characteristics, community resources, pastoral care, and support of family and friends.

Recent investigations apply the Stress Process Model to understanding family reaction to placement in long-term care. Tornatore and Grant6 examined postplacement satisfaction in a cross-sectional survey of 285 primary caregivers, mostly working daughters. They found satisfaction to be correlated with longer duration of caregiving before placement and not working.

Family dysfunction, characterized by negative expressed emotion, poor problem solving, poor delegation of roles, and excessive emotional distance or closeness, has been associated with caregiver burden, although not in a long-term care context.7 Conversely, in a longitudinal survey of 185 caregivers, Gaugler et al8 found that high emotional support pre-placement predicted greater postplacement satisfaction, suggesting that better-functioning families buffer negative emotions such as guilt and depression. Gaugler et al9 looked more specifically at the role of family conflict as a mediator of postplacement adjustment in a separate, longitudinal survey of 165 family members (52 wives, 43 husbands, 67 daughters). Female respondents reported generally high support and low conflict. When wives reported adjustment difficulty, they experienced depression as a result of finding it hard to “let go.” For daughters, adjustment difficulty was more often experienced as guilt, perhaps because of pressure from other family
members to keep a parent patient at home. Men were more likely to report both conflict and poor adjustment, manifested as anger. The authors suggest that men, for whom caregiving is not normative, may be less confident as caregivers, feel as if they quit, and thus more sensitive to actual and perceived criticism.

Application to Practice

Case 2: A previously independent 82-year-old woman is admitted for skilled rehabilitation following a left-middle cerebral artery thrombosis. Her next of kin is her 58-year-old son, a bank officer, who is abrupt and demanding of staff, and appears dissatisfied with medical care. Communication improved once he was able to express his remorse for “placing” his mother, a sense of guilt driven in part by critique from an out-of-state sibling. He also began to realize that partnering with the facility would allow him to maintain his career responsibilities.

As illustrated by this case, research based on the Stress Process Model has several implications for clinicians. First, rapid disease progression or a sudden need for placement may predict more negative emotion about placement. Bridge-building questions based on this information might reflect on whether the caregiver has had time to adjust. Similarly, clinicians can build empathy through acknowledgment of the demands of working while being a caregiver. Second, men and women may manifest distress differently, with women’s responses varied by relationship status. The belligerent male family member may be less angry with the clinician and facility and more angry at himself for perceived failure as a caregiver. Exploratory questions based on these hypotheses may promote empathetic understanding and more open communication as a result. Third, family relationships and family function are significant modifying influences that may act as stressors that hinder communication or as a buffer that fosters positive interactions with clinicians and staff. The impact of family function on communication is considered more fully in the section to follow.

Family Systems Theory

Mitrani et al. have begun to incorporate Family Systems Theory into the Stress Process Model to understand more specifically how family function affects caregiving and its outcomes. In a study of community-based caregivers, they measured family function as an intervening factor in the relationship between objective caregiver burden and caregiver distress. They found that problematic family functioning significantly increased objective caregiver burden (confidence interval [CI] = 0.0223, 0.1362; P < .05) and explained an additional 6.7% of the variance in caregiver distress above and beyond that attributable to other predictors (ethnicity, income, relationship status). This study provides empirical support for incorporating Family Systems Theory into the Stress Process Model. Similar studies in long-term care are needed.

Mitrani et al adopt Structural Family Theory as their specific framework. Developed by Minuchin, Structural Family Theory postulates that family interactions are regulated predictable patterns (structures) that determine how family members communicate and interrelate. These patterns are often passed from one generation to the next, and are relatively stable and resistant to change. Whereas healthy families adapt, others become rigid or disorganized under stress such as long-term care placement. Dysfunction may be amplified when long-term care placement occurs along predictable changes in the family lifecycle (retirement, departure of adult children), or unpredictable stressors such as a caregiver’s loss of job or change of residence.

Application to Practice

Problematic structures, which may impact family interactions in long-term care include Enmeshment, Disengagement, Hierarchies, Triangulation, and Coalitions. How these may impact long-term care practice is illustrated with the following vignettes. Because there is no empirical research on the impact of maladaptive family structures on reaction to long-term care placement, examples are based on the authors’ experience.

Case 3: A 90-year-old woman is admitted to a facility’s dementia unit because of progressive cognitive decline. Her daughter, who resembles the patient, answers for her. The daughter becomes extremely distressed when the patient is treated for a urinary tract infection without first consulting her.

This vignette illustrates enmeshment, a state characterized by poor individualization, amorphous interpersonal boundaries, reduced autonomy, and high emotional reactivity. Enmeshed families may be overprotective and overinvolved in care. Severely enmeshed families may be closed to outside influence (from staff or physician), have unrealistic expectations, or insist on overly aggressive care. Clinicians may improve communication with enmeshed families by frequent updates, acknowledging the family as “watchdog,” and finding constructive ways in which the family can participate in care.

Case 4: A 79-year-old man with degenerative arthritis, anxiety, and mild dementia is admitted to assisted living. He frequently seeks attention for minor complaints. His daughter lives a few miles away but never visits and feels her father should be “DNR” despite the relatively mild nature of his physical and cognitive impairments.

Here, disengagement is described, a relatively uncommon pattern manifested by family members who are emotionally distant or unresponsive. They may use denial or diversion in response to efforts to discuss care plans, may be unwilling to discuss advance directives, or inclined to limit care prematurely. Disengagement may be a marker for caregiver depression, burnout, or poor health, or the result of prior abuse by a parent who is now the long-term care patient. Gentle exploration for these issues may be cathartic to families and allow for referral so that caregiver needs can be addressed as well.

Case 5: A 95-year-old woman with renal failure, spinal stenosis, and dementia has fallen repetitively in her independent-living apartment, prompting the staff to recommend a move to the nursing care unit. Her son, a physician, instead blames inadequate staffing for her falls and challenges her degree of cognitive decline. He agrees to the move only after
Coalition: Collusion of some family members against

Triangulation: Third person is drawn into a 2-person system

Disengagement: Family members are emotionally distant or unresponsive

Hierarchies: Overt or covert family leader/health expert

Enmeshment: Excessive closeness and emotional reactivity

Coalition: Collusion of some family members against others

Table 2. Examples of Maladaptive Family Structures in Long-Term Care

<table>
<thead>
<tr>
<th>Structure</th>
<th>Definition</th>
<th>Example</th>
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<tr>
<td>Enmeshment</td>
<td>Excessive closeness and emotional reactivity</td>
<td>The excessively attentive, demanding, emotionally labile family; may continue to seek &quot;curative&quot; care</td>
</tr>
<tr>
<td>Disengagement</td>
<td>Family members are emotionally distant or unresponsive</td>
<td>May suggest caregiver burnout, depression, poor physical health, or a patient who was an abusive parent</td>
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<tr>
<td>Triangulation</td>
<td>Third person is drawn into a 2-person system to buffer conflict between that dyad</td>
<td>If index patient buffers conflict, family may be unwilling to limit care; families may reduce conflict by channeling this into discontent with clinician or facility</td>
</tr>
<tr>
<td>Coalition</td>
<td>Collusion of some family members against others</td>
<td>Clinician may be drawn in and inadvertently take sides</td>
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neuropsychological testing documents the severity of her deficits.

The hierarchical family is one with a family leader or health expert who may see suggestions from the clinician as a challenge to his or her authority. The clinician would do well to form a partnership with the family leader to the extent possible, and to call on objective data to support his or her recommendations when there is disagreement.

**Case 6:** The daughter and son-in-law of a bedfast, 81-year-old nursing home resident frequently argue with one another when visiting. Their conflicts diminish as they “unite” in criticism of the facility when the patient develops a pressure ulcer.

This case illustrates triangulation, which occurs when a third object is drawn into a 2-person system to diffuse anxiety or reduce conflict. The third party may be an organization as in this example but is more often a person such as the attending physician or a facility staff member. The conflicting dyad may attempt to communicate with one another through this third individual or redirect their conflict into interactions with him or her. Thus dissatisfaction and communication problems may serve a stabilizing or homeostatic influence in this context and thus be difficult to improve. Similarly, if the index patient buffers conflict among other family members, they may be unwilling to limit care. While resolving triangulation may prove difficult, recognizing the pattern may reduce clinician frustration and allow for setting healthy boundaries.

**Case 7:** The wife of a 90-year-old man with moderate dementia and a stroke requests a PEG-tube. The 2 daughters take the physician aside, expressing concern that their mother’s request is motivated by guilt and offer to help “protect” their father.

This is an example of a coalition, conscious collusion of one faction against other family members. This pattern is seductive, as it may play to physician biases. Certainly most physicians would wish to avoid a PEG tube in this instance as being unlikely to benefit the patient. The alliance of shared beliefs may also be reinforcing. However, taking sides is likely to entangle the clinician in deeper family conflicts and produce distrust. Encouraging all stakeholders to talk out differences of philosophy is a wiser course.

As summarized in Table 2, this section has highlighted how theoretical understanding can inform communication with families. The Stress Process Model offers a structure for appreciating how families react to placement of a loved one. Resultant insights can stimulate empathy-building questions and comments, thereby promote family adjustment, satisfaction with care, and other positive outcomes. Both the Stress Process Model and Family Systems Theory can help clinicians understand and thus take less personally family anger and other negative responses. Empathetic engagement, problem solving, and avoidance of defensiveness and personalization, key strategies suggested by Winn et al, are thus more possible. Family Systems Theory can also highlight other dysfunctional patterns of interaction in order to avoid pitfalls and to most appropriately frame communication. The purpose of recognition is not for “fixing” family dysfunction, which requires a higher level of physician training and involvement, as discussed in the section to follow.

**A MODEL FOR RUNNING A FAMILY MEETING**

Doherty and Baird originated the Levels of Physician Involvement Model in the 1980s as a curriculum development...
They stipulate 5 developmental and incremental levels of physician learning and skills with respect to working with families (Table 3).

Level 1 views the family from a biomedical perspective as a source of information. Level 2 represents formation of partnerships to elicit family perspectives. Level 3 pertains to engaging families on an emotional level, through provision of support and facilitation of positive coping, but stops short of changing the family system. Level 4, systematic assessment and planned intervention, involves changing family systems, and level 5, family therapy, entails treatment of family dysfunction.

**Application to Practice**

We suggest that long-term care clinicians be adept at levels 1 through 3. Levels 4 and 5, improving family function and treating dysfunctional families, lie beyond the responsibility of the long-term care clinician and require specialized training in family systems and family therapy that is beyond the scope of most generalist or geriatrician training and experience. Thus, we view the need for level 4 or 5 involvement as a threshold for referral, although basic understanding of these levels is needed to recognize the need for referral and to avoid pitfalls. We now consider these levels in greater detail, as they relate to planning and conduct of a family meeting.

Level 1 involvement concerns data collection for the purposes of assessment and planning. This begins with an assessment of the long-term care patient, his or her pre-placement history, medical conditions, cognitive and functional abilities, resources, and goals of care. Much of this information is already available from admission functional assessments, review of hospital records, and the medical history and exam. The family becomes an important source of collateral and historical information. Level 1 observation might also be extended to the “other” patient, that is, the family itself, through unobtrusive observation, noting who’s there and who’s not, who sits near whom, body language, who talks and who doesn’t, who is the leader, and who argues or agrees with whom. These data can help the clinician identify dysfunctional patterns suggested by Family Systems Theory and select communication strategies.

**Table 4. Communication Facilitation Techniques**

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<tr>
<td>1</td>
<td>Normalizing (when faced with this situation, many people are stressed/depressed/angry/guilty/etc.).</td>
</tr>
<tr>
<td>2</td>
<td>Give permission to feel mixed and negative emotions.</td>
</tr>
<tr>
<td>3</td>
<td>Allow 1 person to speak at a time (“I” statements).</td>
</tr>
<tr>
<td>4</td>
<td>Be sure everyone has a chance to say something if they choose.</td>
</tr>
<tr>
<td>5</td>
<td>Reframe negative or judgmental comments.</td>
</tr>
<tr>
<td>6</td>
<td>Use reflection for clarification (state back what you understand to have been said).</td>
</tr>
<tr>
<td>7</td>
<td>Emphasize strengths and positives (how have they coped successfully in past).</td>
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Levels 4 and 5 involve changing the family system and family therapy. Such interventions are not the responsibility of the long-term care clinician and involve specialized training. However, an appreciation of these levels can alert the clinician to communication pitfalls. These include being caught in conflicts (triangulation) and taking sides (being pulled into coalitions). Additional hazards are not having a meeting at all, thereby fostering distrust, and talking before listening, thereby ignoring family misconceptions and concerns. Also, the patient, if able to understand, should be aware of the meeting, give his or her consent, and should be included in proceedings where appropriate. Appreciating levels 4 and 5 can bring the clinician in touch with his or her own family-of-origin issues. Such issues clearly influence response to family and patient. Understanding these can make one a more effective meeting facilitator and communicator.

**CONCLUSION: BARRIERS AND SOLUTIONS**

This article has reviewed the translation of theoretical perspectives into pragmatic approaches for working with fami-
families, through an initial family meeting, and over the course of the long-term care experience. Suggested approaches do not require specialized behavioral training and many clinicians may already have been exposed in the course of their training. Necessary communications skills have been summarized here in what is intended to be a succinct review. Greater detail is available in McDaniel et al’s 2005 textbook, *Family-Oriented Primary Care*.17

Despite these resources, family-oriented counseling can be perceived as a challenge. One barrier, the management of conflict, can be addressed in several ways. The clinician can help by clarifying understanding (I understand that ________ is important to you in your relatives’ care). Other strategies include seeking compromises, finding common ground, and helping the family weigh risks and benefits of alternative courses. Family education may also prove helpful, augmented by written and electronic resources.18 When all avenues are exhausted, stating the limits of what one can and cannot do is prudent while awaiting further development and family movement.19 Some families may be open to referral for counseling.

Conflict may also occur if there is a disconnect between the culture of medicine and family health beliefs. Asking in a general way whether previous encounters with health care and health care providers have been positive or negative may elicit critical events in the past that shape current views. Once recognized, these barriers can be addressed by education, reassurance, and building relationships. Culturally and contextually competent communication is vital in these situations but lies outside the scope of this review. The interested reader is referred to reviews by Kagawa-Singer and Blackhall and others.20

Clinicians may be daunted by concerns about time demands and interpreting verbal and nonverbal communication. These constraints will lessen with adopting a team approach. Including nurses, nurse practitioners, mental health professionals, chaplains, and others as part of the meeting allows for a range of different communication styles that may complement one’s own. Also, team members may observe things the clinician, preoccupied with running the meeting, may not pick up. Examples here include appearance, affect, nonverbal communication, seating arrangements, speaking order (including who does not speak), tone of verbal communication (including mis-matches between what is said and what is meant), and other interactions among family members and between family members and staff. These observations can be critical to interpreting and responding to family behavior, and can be discussed in team meetings, and subsequently applied.

A team-based approach to family meetings is more than the sum of its parts. Interdisciplinary planning for a family meeting can suggest goals and strategies that might not be apparent to the medical director or attending physician nor to individual team members. Similarly, interdisciplinary discourse following the meeting can foster understanding, suggest novel solutions, help team members cope with difficult families and situations, and improve linkages with external and community resources for families. Informal communication across disciplines boosts morale and creativity, unburdening the individual clinician and empowering all involved. Ultimate beneficiaries include both long-term care patients themselves and the families that care about them.

REFERENCES


