partners/spouses would not be homeless if we died first. There was variation between us in how frank and open these discussions could be in our respective families.

We all developed and enjoyed a sexual life with our new partners. And not surprisingly we were all bothered by the appearance, health and functioning of our ageing bodies, for example, wrinkly skin, varicose veins, teeth that come out at night, and of course, the bits that drop off…we were so preoccupied with the question of whether our partners would be put off by the sight of our nakedness that it never occurred to us to consider that they might have held similar doubts and fears! Once we overcame this initial shyness, we all reckoned that learning from life experience held us in good stead in how we approached and navigated our sexuality and sexual relationship. And sadly, this is where we encountered some of the social discourses around ageing and sex. We were greeted with expressions of joy and gladness at one extreme and barely concealed disgust and 'aren't you a bit old for all that', at the other extreme.

A sense of time running out was expressed by all. We had crossed the line between years I have lived and years I have left to live. This helpfully intersected with a belief that we were in some ways wiser with experience. We all knew the value and significance of resolving and healing unintended hurt feelings for ourselves and each other, and importantly recognising in our new partners their attempts to heal a misunderstanding, even if we were not quite ready. This is not to say we were never naïve. We continued to be surprised and some of us spoke about 'firsts' with our new partners – experiences and events that we had not anticipated. We were committed to learning and development, and we were grateful for the opportunity to live love a second time.

Late Fragment

And did you get what you wanted from this life, even so?
I did.
And what did you want?
To call myself beloved, to feel myself beloved on the earth.
Raymond Carver (1938 – 1988)

Paul is a retired mechanical engineer. He still loves to fix things.

Arlene is a family therapist. Sometimes she still struggles to turn her knowledge into action in her own life.

A catch-up on research and evidence for systemic therapies in later life

Sophie Jeffery

Search strategy

With help from my NHS trust library service, I conducted a search of databases PsychInfo, Medline, EMBASE & CINAHL for articles since the year 2000 using the terms 'family therapy' or 'multisystemic therapy' or 'systemic therapy', and 'later life' or 'geriatric' or 'elderly' or 'dementia'. One limitation is that we did not specifically search for 'couples'. I screened the results and found 55 relevant papers. Here I offer an overview of themes and developing evidence across these articles. I also identified a handful of articles which may be of particular use, and invited guest reviewers to describe these in more depth at the end of the article.

Review

The search generated articles predominantly from the USA, followed by northern European countries, Hong Kong and China, and a small number from Asia and Australia. This indicated a predominance of writing about systemic therapy in later life coming from the northern hemisphere. There were significant cultural variations in social and healthcare systems which cannot be meaningfully summarised here.

The papers commonly began with statistics about the growth of ageing populations, the need for therapeutic support for mental health, dementia and other health concerns, and therefore the demand for specialists in later life issues. Some papers offered interesting discussions of specific issues which families might negotiate in later life. Qualls (2000) explored lifecycle transitions and realignment of family structure in later life. Evans (2004) suggested that discussing sex, domestic violence, death and changes in living environments may be important for couples. Peisah *et al.* (2006)

explored conflict in older people's families, particularly between siblings. Barber and Lyness (2001a) highlighted how families caring for a person with dementia face ethical dilemmas around autonomy, truth-telling, justice and filial obligations. Richman (2001) discussed the value of exploring suicidal behaviour across generations when an older person expresses suicidal ideation. Yorgason *et al.*, (2010) explored the influence on therapeutic alliances and couple dynamics when one spouse acquires a hearing impairment.

Ageism seems to pull in the opposite direction of growth, dampening the provision of systemic therapy with older people and their families (Garner, 2003). Ivey *et al.* (2000) found that, irrespective of training in marriage and family therapy, people viewing the same vignette about a couple with only the ages changed judged a younger couple's issues to be more serious. Barber and Lyness (2001b) found that only 8.9% of marriage and family therapy training courses in the USA included any content on gerontology or later-life families. It cannot be surprising therefore that not only is the provision of systemic therapy with older people patchy, but that the evidence remains seriously limited.

The vast majority of papers which reported research were about interventions with the carers of people with dementia. This reflects a concern with reducing the psychological burden on carers, stress and depression, and improving quality of life. Outcomes were often positive and supported the value of intervening with this group (Brodaty & Arasaaratnam, 2012; Mittelman *et al.*, 2008). Many authors offered useful recommendations about how to improve access to therapy using communication technologies and tailoring according to culture (Llanque *et al.*, 2012;

Bank *et al.*, 2006; Eisdorfer *et al.*, 2003). The elements of effective dementia-carer programmes varied widely, and were never wholly psychotherapeutic. Group interventions seem to offer valuable peer-support (Fung & Chien 2002; Wang *et al.*, 2012). Most had educative elements, such as training carers in communication skills (Haberstroh *et al.*, 2011), problem solving (Wang *et al.*, 2012), and practical caring skills (Lai *et al.*, 2001). Others focused more on the carers' coping strategies (Cooper *et al.*, 2012), and teaching them to make cognitive reappraisals towards 'benefit-finding' (which could be thought of as reframing or positive connotation) (Cheng *et al.*, 2017).

Most of the interventions for carers of people with dementia were not overtly underpinned by systemic principles (and often not clearly described at all). One exception is the Structural Ecosystemic Therapy model described by Mittelman *et al.* (2007) as a structural family therapy approach aimed at enhancing the adaptation of the family to caring for a member with dementia (this is discussed below in the review of Eisdorfer *et al.*, 2003). I was left wondering if the model of support for carers of people with dementia is significant, and whether systemic principles add value compared to other non-systemic approaches with similar aims.

The understanding we can gain from such studies is limited by a general focus on individual carers' outcomes (burden, stress, depression, quality of life). Very few studies assessed relational or systemic outcomes of supporting carers such as relationship quality and satisfaction or family functioning (Goodazi *et al.*, 2017), despite evidence that relationship quality may be an important factor in predicting distress and functioning (Braun *et al.*, 2010; Burgener & Twigg, 2002; Tremont *et al.*, 2006). In terms of indirect systemic effects of carer interventions on the person with dementia, it seems interventions may have an impact on behaviour and mood problems (Droes *et al.*, 2000). Joling *et al.* (2012; 2013) found that supportive family meetings did not delay moving into a care home or reduce the cost of care, but Mittelman and colleagues (1996; 2006) reported postponement of nursing home placements with family-centred care and counselling.

One arena which received some attention in terms of the value of thinking systemically and bringing family and care staff into therapeutic work was in care homes

(Duffy, 2002). A lovely paper from Faber (2003) describes using the collaborative language approach to develop dialogical conversations with older people living in care homes, counteracting the tendency towards loss of dialogue and communication in such settings. Massingham and Perham (2005) explored the application of narrative therapy with grief work, a common theme in older adult therapy. These were the only papers describing individual systemic therapy with older people and focused on narratives and language rather than on family relationships. This attests to the slow adoption of innovations in systemic therapy with older people. I think there is great potential for exploring contemporary dialogical, collaborative, attachment, narrative and emotion-focused approaches, as well as models such as multi-family therapy, with older people.

There was a paucity of research about direct systemic therapy with older people generally, particularly those who do not present with dementia. Nonetheless, several authors advocated offering family therapy with older adults and discussed the applications of a variety of direct and indirect therapy and systemic techniques (Tisher & Dean, 2000; Qualls, 2000). Peisah (2006) discussed offering family therapy for *"(i) the treatment of chronically depressed older people in the community; (ii) the management of behavioural and psychological symptoms of dementia … in residential care; and (iii) home-based support and care of the older patient with dementia"*. When considering functional mental health and family relationships, there is likely to be significant overlap in the practice and effectiveness of family therapy used with younger adults. It would be interesting to hear discussion of the limitations and benefits of extrapolating from such research. There are also reasons to believe that the content and form of family therapy would vary within the older adult population due to cohort effects (for example, the generational discourses and experiences of the baby-boomer generation are significantly different to those who experienced the second world war).

The papers predominantly focused on older heterosexual couples, with some coverage of different generations. There was just one discussion paper found about lesbian older people from the USA (Neustifter, 2008), and no research on older lesbian, gay, bisexual, transgender, transsexual or

queer families. Cross-cultural evidence is limited to looking at papers from countries of origin, rather than providing a view of the influences of migration and merged cultural experiences. Smith and Harkness (2002) explored the role of spirituality with dementia caregivers. Evidence and writing about intersectionality of identities and 'social graces' in later life was absent.

Conclusions

There is a developed discourse about the need for psychotherapeutic approaches for older people and their families. Many of the writers argued that systemic models of change and therapeutic approaches have good potential for this group. Research over the past twenty years has made little headway in offering evidence for or against systemic psychotherapy with older people. This may be due to a lack of training and interest in this specialism, and probably a need for stronger leadership from AFT and training institutions in this regard. We hope the current special issue of *Context* will contribute to making this rich area of practice more visible. The field is open for gathering family therapy evidence across the breadth of older adult presentations (particularly building beyond the current focus on dementia), working with couples and individuals, exploring applications of more contemporary systemic therapies, and considering in much richer detail the differences among people aged over-65.

Brief reviews of key papers
Górska *et al.* (2016) *Family group conferencing in dementia care: An exploration of opportunities and challenges*

Family-group conferencing aims to empower families to lead decision-making about care. Originating within children's services, it has also been applied in adult care. Although the evidence base is limited, the authors tentatively identify the potential relevance of the approach for people with dementia and their families, presenting a qualitative exploration of the impact of a pilot service.

I was unfamiliar with family group conferencing before reading this paper and interested to learn more. Key principles of the approach include voluntary participation of families, independence of the coordinator from any professional involvement with the family, and specific skills to empower family-oriented practice.

Focus groups with family members and professionals identified strengths and challenges of the pilot project. Family conferencing was seen as an opportunity to bring the family together and highlight their strengths and resources. Participants also valued the development of an alternative perspective on dementia care, moving away from expert-led decision making. However, there was acknowledgement of wider systemic factors which could challenge this culture change in practice.

Other challenges identified included facilitating meaningful involvement of the person with dementia with family group conferencing and managing pre-existing family dynamics. Although promising, more research is needed regarding specific skills to adapt the approach for people with dementia and their families, and to integrate such an approach into existing health and social care service cultures.

Anna Strudwick

Wang, Chien and Lee (2012) *An experimental study on the effectiveness of a mutual support group for family caregivers on a relative with dementia in mainland China*

This paper provides practitioners with a helpful intercultural template for connecting Western therapy group practices, in a way that helps to privilege the indigenous intercultural nuances and experiences of the participants in the mutual support group.

The study encompassed 12 fortnightly sessions of a mutual support group, and corresponding control group, where participants were not involved in family therapy. The mutual support group received psycho-education into the effects of dementia and a space to talk. The effect of the treatment on the participants was wide-ranging, including insight into both symptoms of dementia and corresponding behaviours. The provision of a mutual peer group where they could share their concerns reduced their feelings of discomfort, distress and enmeshment from dementia. It helped develop practical strategies in their carer role to re-route their negative experiences to positive thinking and strength-based solutions.

To further enhance good outcomes in future studies and group clinical practice, incorporating a translated Score-15 Index of family functioning and change may be useful. This is a short, self-report outcome measure,

designed to be sensitive to the kinds of changes in family relationships that systemic therapists see as indications of useful therapeutic change. Administering this tool at intervals could illuminate the process and timing of cultural aspects of practice, which are important for inter-sessional change for clients. This would then provide practitioners with knowledge and skill-sets for embedding culturally competent practice.

Karen Carberry

Sinclair *et al.* (2018) *How couples with dementia experience healthcare, lifestyle, and everyday decision-making*

This paper focuses on couples' approaches to decision-making and the factors influencing these approaches. The research method was an interpretative phenomenological analysis of semi-structured qualitative interviews with couples and individuals who were either a person with dementia or their spouse. Couples described encountering healthcare decisions (help-seeking, establishing diagnosis, navigating healthcare systems, accessing care services, responding to crises and advance care planning); lifestyle decisions (living arrangements, employment, civic participation, holidays, pets, important possessions) and everyday decisions (shopping, driving, household maintenance and chores, interactions with family and friends). Different approaches to decision-making emerged: independent (made by the person with dementia), joint (made by both partners on a relatively equal basis), supported (the person with dementia was assisted) and substitute (the partner made the decision).

For clinicians, the paper highlights the complexity inherent in decision-making for couples. Also highlighted was the symbolic significance of certain kinds of decisions, another crucial point for clinicians to explore. The significance for the partner with dementia of "being known" by their partner and trusting in their partner to make decisions based on their preferences was discussed. However, because of this factor, many of the couples in the study eschewed advanced-care planning, assuming partners would know what to do on their behalf. The paper recommends that clinicians may need to challenge couples to consider this aspect of decision-making and help couples to look at these decisions from a relational perspective, consider future scenarios where either partner was incapacitated, and encourage joint decision-making. The paper

states that this research provides a useful toolkit for clinicians to use with these couples but may only provide a starting point. Pre-dementia decision-making was not examined and could provide an additional storyline for exploration. Also, the diversity of participants was not wide and future studies could include ethnicities and lesbian, gay, bisexual, and transgender relationships.

Sarah McConnell

Eisdorfer *et al.* (2003) *The effect of a Family Therapy and Technology-based Intervention on Caregiver Depression*

This is an interesting paper that addresses the depression of carers by extending the structural approach to include their wider social network of potential support. The authors call this development structural ecosystems therapy. This form of therapy builds on standard structural family therapy by identifying interactions in the family that might address the burden of the caregiver, improve their capacity and bring resources from both family and community to address and enable a collaborative effort. It is this last part of also involving their community that gives it an ecosystems approach.

The aim of the study was to change behaviour in the care-giver's system, thereby addressing the stress of being in a caring role and stimulating support. The study is applied to two different ethnic groups in the USA: White Americans and Cuban Americans, and two different relationship types by applying the intervention with partners and daughters. They incorporate the use of the texting technology, so carers can send and receive emails and conference calls and be part of online support groups. The technology is also used to engage people who are unable to attend the family sessions in person.

The findings were that structural ecosystems therapy plus technology had the best outcomes: lowering depression in caregivers at both six- and eighteen-month follow up for both ethnic groups, with both spouses and daughters. The approach on its own did not make a significant difference to levels of depression in carers of any ethnic background. Ethnicity is important to consider, because structural ecosystems therapy plus technology was successful in lowering depression significantly in families with a Cuban-American background.

Gill Wallis

Carpenter and Mulligan (2009)
Family, know thyself: A workbook-based intergenerational intervention to improve parent care coordination

This article is about a pilot study using quantitative methods to test out the impact of a "work-book based intervention" in enhancing intergenerational collaboration in older-parent care coordination. The workbook was designed to provide tools that a facilitator could use to help and guide families through topics of parent care. Results of this study suggested that older parents and adult children have different ideas about parent's needs and wants and that these examples require intervention to improve family communication skills and knowledge.

The article is reader friendly, informative and the content engaging, encouraging curiosity and imagination. The idea of structured chapter headings and shared learning rather than family dysfunction could promote talking. Some drawbacks include written activities which seem more dominant than actual talking between people, cost effectiveness of facilitating the process of inter-generational learning, single one-hour education sessions insufficient for families to consider and digest key issues on ageing and also to develop a comprehensive and informed workbook. The relevance for practitioners is the idea of an empirically based tool with potential for adaptation to encourage talking about parent-care plans and coordination.

Victoria Sharman

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