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THE GENOGRAM IN (PSYCHO)GERIATRICS: AN INDISPENSABLE TOOL

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SUMMARY

Background: *This article proposes a reflection on the use of the genogram in the management of (psycho)geriatric patients. Understanding family dynamics seems essential in the management of elderly patients, confronted with multiple changes in psychological, physical, social, financial aspects etc, and who present chronic complaints, despite multiple treatments and cares.*

Subjects and methods: *We realized a literature review based on articles dating from 2005 to 2023 and selected from following danabases: Pubmed, Cochrane, Scopus, Cairn, Psychinfo and Google. Used key words are "genogram", "family", "(psycho)geriatrics", "symptom".*

Results: *Thanks to the analysis of the patient's symptomatology through the prism of relational and contextual dynamics, the genogram offers a reading grid on the family system. It allows us to understand the places and functions occupied by each person, their life story, relational issues, the open and hidden conflicts, their family and social representations… This is done by taking into account the context in which we meet a patient and his/her entourage. This reading grid also allows caregivers to avoid reproducing the same interactional modes in the care of the patient and his or her family, which makes it possible to fight against the chronicization of the symptom.*

Conclusion: *The creation and analyse of the genogram aim to offer another point of view, in relation to the management of complicated families and/or patients with chronic symptoms, without associated organic origins. The goal is to move away from a linear vision and causality (cause-consequence) to offer a systemic reading grid. This is in order to understand the various relational issues associated with these complex family and interactional dynamics.*

Key words: *genogram – symptom – family - (psycho)geriatrics*

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INTRODUCTION

The importance of the bio-psycho-social model in the field of care for elderly patients is no longer to be demonstrated. Indeed, aging is a dynamic process involving multiple physical, psychological, functional, cognitive and social changes, which are inevitable and irreversible (Clement 2019). From the age of 65, humans can be led to go through the state of "old age". This transition exposes us in a general way to the principles of vulnerability, challenging our illusion of immortality. It is often experienced as a rupture in which we are confronted with losses, real and symbolic (loss of autonomy, loss of ability to adapt, etc.). This confrontation, sometimes brutal, gives rise to a feeling of loss of control and powerlessness for the subject but also, frequently, for his or her family circle (Cohen et al. 2014). Their family organization is shaken, and they will have to reorganize. Thus, in the face of multiple reshuffles, some patients or their families will present persistent complaints, despite multiple assessments and care: "doctor I am in pain"; "doctor, my loved one no longer eats"; "the nursing home can no longer stand the patient's attitude"; "Mr. insults and has been aggressive since his admission" etc. Therefore, with advancing age, and in the absence of additional cognitive disease, multiple requests for care concerning painful complaints, behavioural disorders or psychosomatic complaints seem to become chronic, despite the assessments and care, leading to exhaustion of the patient, his relatives but also the caregivers (Delage et al. 2017). In addition, there will often be meetings with families, which are sometimes difficult, especially with families who are hyper-invested, intrusive, or even non-existent. So, it will be important to identify resistant problems which seem to go beyond the "medical" aspect in the strict sense. The standardized geriatric assessment is one of the many tools in geriatrics, which makes it possible to investigate in part the spheres of mental health, the socio-financial situation and the environmental factors of the patient (Clement 2019). Nevertheless, the family dynamics in which the patient evolves often seem to be little investigated. However, does it not influence the patient's complaints and behaviours, as well as the dynamics of care and therapeutic objectives? Can the genogram help us in this understanding? And if so, how? The purpose of this literature review is to show its potential interest in psychogeriatrics, and more generally in geriatrics.

METHOD

We conducted a literature review based on articles dating from 2005 to 2023. The search engines used were CAIRN, SCOPUS and PsycInfo. The key words used are "family", "geriatrics", "genogram", "systemic approach".

RESULTS

First, it seems important to define what we mean by the concept of "symptom" (Carr 2012, Delage et al. 2017). Although a patient is a carrier of a symptom, the systemic paradigm attributes to the term "symptom" a different function and meaning than the medical symptom itself. It represents here a real relational tactic, that is to say a means of communication within the system. According to Haley, the symptom exists under 2 conditions: on the one hand, it has an influence on others, and, on the other hand, the patient is powerless in the face of the symptom, i.e. he does not do it "on purpose" (Meynckens-Fourez & Henriquet-Duhamel 2005). The carrier of the symptom is called the "designated" patient because it reflects the interrelational and communicative dysfunction within the family system. The appearance of the symptom reflects what the system must produce to continue to operate, reflecting the struggle of the system between maintaining its cohesion and changing. Let's keep in mind that an individual's way of being is modulated by the context but also by the answers he receives from others. So indirectly the system “helps” to maintain the symptom (Meynckens-Fourez & Henriquet-Duhamel 2005). The identification of these interactions and relationships games is important. The role of the therapist is therefore essential because it implies moving away from the idea of linear causality (i.e. a problem with a cause and consequences) to reason in a circular way, in terms of interactions: one attitude feeds another and vice versa.

Secondly, the genogram is a systemic tool, allowing a graphical representation of the family tree of a patient. It often extends over 3 to 5 generations and allows the person who draws it to have a structural representation of the family, and to relate life events within the family (date of birth, date of death, etc). It makes it possible to investigate the "family" in the biological sense of the term but at the legal, imaginary or socio-cultural level too (Daure 2010). So the genogram includes a genealogy but also a psychosocial aspect, in particular through the representation that each person has his/her own history: to do so, it can be completed by symbols, designating relationships and their intensities; annotations of significant events, characteristics of individuals, professions, manner of death, etc. In addition, the genogram involves differentiating the "links" that unite each member of the system (biological, immutable links) from the « relationships » (co-constructions between individuals, chosen, modular). So, everyone has the choice to be in relationship with a particular member of a group, while keeping in mind that relationships evolve according to the context (see below). The genogram explores important life events (marriage, divorce, separation, illnesses, accidents, traumas, uprooting, professions, etc.), the myths and rules that govern the family. Thus, this tool allows access to a large amount of information, in particular with a view to drawing up relational hypotheses relating to the functioning of a family but also contextual ones. Indeed, it is essential to analyse a systemic dynamic by considering the context in which we meet the patient and his system, in particular the stage of the life cycle in which they are. Patients over 65 years of age have to deal with multiple changes: see your children leave, welcome stepchildren; become grandparents and great-grandparents; stop working and discover a new and different social life; caring for or grieving one's own aging parents; decide where to live; accept a possible regression in one's physical and psychological functions, or those of one's partner; losing one's partner; discuss the legacy you are going to pass on,... These changes influence the patient, his/her experience and feelings but those of the groups to which he belongs, especially his family too. Thus, the patient and his system may find themselves in a transitional situation, that is to say a change of phase in their life cycle where they are confronted with the need to adapt in order to restore a state of equilibrium. The system will have to adapt and reorganize, both in terms of places, functions, values, etc., in order to regain homeostasis. If the patient and family are « flexible », they will mobilize resources to find this state of balance by themself. Conversely, if they don’t accept this change of state, they are considered as rigid by remaining "stuck" in an old mode of functioning, which can be the cause of complaints or symptoms.

So, the genogram offers, through this co-creation, information about:

- The places and functions occupied by each member of the family, and which evolve in particular according to advancing age, losses and changes that the family is going through. For example, it is not uncommon to see children become "parents of their parent" or, conversely, parents refusing to involve their child in their care. These redefinitions (or not) of places can lead to confusion within the family functioning, potentially a source of tensions and conflicts that we will have to identify and clarify (Daure 2010).
- Family myths, i.e. the beliefs shared within the family, which are expressed through the family narrative "In the family, we are like this or like that." The myth feeds the bonds and the experience of belonging within the family but also certain representations "In the family, we all have heart problems; we die of heart diseases"; "In the family, children take care of aging parents."
- Representations of each person, particularly in the face of symptoms, illness or death: how do we manage illness, suffering, physical pain in general in the family? How do we express them within the family: the body, the words, the silence, the anger...? How do we behave in the face of the disease? etc. It will be important to work on the differentiation of the patient's self, in relation to the representations that he, and his partner, have of illness or death (Daure 2010, Iriartre 2023).

- Family loyalties: "to whom or to what are we loyal in the family?" This analysis will be important in families in which forms of abuse, neglect or intra-family violence have been or are still observed, for example a child who remains loyal to his or her parent "no matter the past, he remains my parent, I owe him my life" (Heireman 2010).
- Latent problems: the patient, the couple or the family can tell their story through the anger, arguments, traumas, disputes, family secrets or frustrations they have experienced (Andolfi 2018).

Regarding all the points mentioned above, the realization of the genogram is both complex and simple. Complex because, as said before, it offers multiple fields of investigation, and therefore requires time. It is not created in one consultation and requires a certain degree of therapeutic alliance, so it is not done during the first meeting. Conversely, it is simple, in the sense that there is no right way to establish a genogram: it adapts to the clinical practice of each caregiver and each situation. The method of investigation involves soliciting the patient, and his/her family to co-create the genogram. The collection of information is done through interviews and meetings (Alexander et al. 2022). It should be noted that a genogram can be used when we are faced with a patient individually because the symptom is part of an interactional mode of the patient with a system of belonging, whether family, therapeutic or other.

DISCUSSION

It should be remembered that each ageing is different and is experienced in a unique way by the patient, his family, his entourage. The state of old age involves the elderly person facing multiple changes in psychological, physical, social and relational conditions (Cohen et al. 2017). In addition, there is the announcement of acute illnesses, the evolution of chronic illnesses or psychosocial difficulties (Delage et al. 2017). Consequently, the patient elderly is confronted with his history, taking stock of this life, with its successes but also its failures, its guilts and its frustrations. He finds himself confronted with old conflicts, resolved or not, and with the phenomena of regression. Considering these disappointments and losses, real and/or symbolic, the system in difficulty counts given its history and mode of operation, can find the solution of designating a patient, carrier of one or more symptoms. The family will then organize itself around the latter, tending to preserve its "usual" state of functioning, of homeostasis. When this symptom becomes problematic, the system suffers and will be forced to reorganize itself. The symptoms become chronic when the crisis is not welcomed by the system: the equilibrium prior to the seizure seeks to maintain itself, leading to a fixation that becomes rigid around the symptom (Daure 2010, Carr 2012). The suffering system presents itself to the caregiver, formulating a request for help, which could look like "make it change for him, but nothing changes for us". Thus, in (psycho)geriatrics, we regularly find ourselves confronted with stereotypical symptoms such as weight loss, pain, anxiety, refusal of care, behavioural disorders with agitation and aggressiveness, the experience of loneliness... having already been the subject of multiple assessments and treatment without results. So, caregivers can be confronted with patients and/or families described as "difficult". Some very, even too present; others are more complaining, or even aggressive; some sometimes require a flawless quality of care. Some seems to overcome a form of guilt, wishing to offer their loved one the best for their end of life. Conversely, other families will be detached or even absent. Faced with these situations, the therapeutic system, symbolized by the patient and his caregivers, if it is not aware of family dynamics, risks in turn reproducing what is at stake within the family: an experience of powerlessness with disinvestment, irritation or even a hyperfocus on the symptom, trapping us in what the family is leading us into. The risk is that these complex interactional dynamics can give rise to real value judgments in caregivers: "this patient annoys me", "this family is hellish", etc. Systemic care is therefore essential, at the risk of escalating between the family system and the therapeutic system. The genogram can be used to put the family back in their context, but also to relaunch the clinical process around the system, and not the individual. In this systemic reading, the symptom is read by caregivers as an adaptive solution found in the face of a much larger problem, in a given context. The realization of the genogram therefore gives not only the therapist, but also the family members the opportunity to identify possible alliances and relational issues. The power of non-verbal language, through the visual and graphic aspect of the genogram, often allows the family to become aware of repetitions, power games, places or even functions of each person. The replacement of family members in a chain of relationships contributes to the balance of the roles and responsibilities of each person, particularly in the common construction of the symptom in its "protective function for the system"(Andolphi 2018, Carr 2012). The therapeutic alliance is essential because any attempt to force a change will cause the family to increase its rigidity. The therapist, through the genogram, pushes the family to reflect on their interrelations and communications in given contexts (couple, family, network, etc.). Thus, they talk about their relationship to themselves but also to others and care: in this way, they modify the construction of their reality, with a view to bringing out other possibilities of functioning, in particular by targeting the organizational skills of the family and its members, making it possible to avoid

guilt. This co-construction promotes the involvement of families in the patient's therapeutic process (Alexander et al. 2022, Iriartre 2023).

To conclude, it should be remembered that there are certain limitations to the use of the genogram. The major risk being, as explained above, to lock the patient, and/or his family, into the idea of a "linear causality", i.e. a "cause-consequences" reflection, thus risking compartmentalizing thought around a causality of implacable transgenerational inheritance, blocking the system in any reflection around a change. To avoid this phenomenon, the need to have a good therapeutic alliance is essential and implies differentiating between (biological, immutable) and (chosen and adaptable) relationships. Finally, it will be important to remain vigilant for the existence of possible intra-family violence. For example, it will be contraindicated to use the genogram if the freedom of speech is likely to increase this violence and/or to induce the rupture of the therapeutic link.

CONCLUSION

In the care of a (psycho-)geriatric patients, it will be essential to meet the designated patient, his/her family and entourage. To do this, the genogram allows, in addition to the analysis of family dynamics, an improvement in the understanding of the interactions that will take place between the patient, his or her entourage but also with the therapeutic system. It offers a richer reading grid in the understanding of the symptom and problem of the patient and his system, not limiting the patient's complaint to a linear causality but reminding us that each of the members of a system is inseparable from the whole. It offers the possibility of fighting against the chronicization of certain complaints. This implies a more global systemic approach, integrating the designated patient and his/ her family in their present but also their past interactional dynamics, while considering the context in which they evolve. It allows the caregivers to have a more open vision, limiting the risk of reproducing family relational games within the therapeutic system. Through the co-creation of the genogram, it allows the patient and his/ her relatives to be proactive and actor in their care. In conclusion, the genogram seems to be an essential tool in the care of elderly patients and their families.

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