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Family Dysfunction and the Emergence of Depressive Disorder in an Elderly Resident of a Care Facility: An Analysis Using the Genogram and FAT Techniques

Dr. Salima Bouskine, University of Algiers 2, Algeria
salima.bouskine@univ-alger2.dz

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Abstract

This article aims to examine the indicators of family system functioning as perceived by an elderly person suffering from depression and residing in a nursing home. The study adopts clinical methodology with a systemic approach. The results obtained through the application of clinical tools; namely the semi-structured clinical interview, the genogram technique, and the Family Apperception Test (FAT) to the case of Mr Madjid, an elderly retired man, reveal the presence of profound psychological distress associated with severe depressive condition, that has been experienced since his transition to institutional care two years ago and is characterized by a marked inability to regain pleasure in life and by social withdrawal from other residents of the nursing home.

This psychological suffering was evident in the genogram, with highlighted a dysfunctional family relationship with –in-law. Furthermore, the analysis of the FAT protocol revealed a very high index of family system dysfunction (index=52), with a pronounced emergence of family and marital conflict. There was also an elevated stress factor index related to the maternal figure, a role assumed by the daughter-in-law, along with a marked predominance of negative affects such as depression and sadness. In addition, a significant projection of anxiety and fear was observed, reflecting Mr Madjid's position as the weakest link within this family system, upon whom the symptom of the dysfunctional family system have been displaced in the form of Major Depression Disorder.

Keywords: family system; elderly person; depression; genogram, the FAT

Introduction

The family system constitutes a fundamental theoretical construct in family psychology and sociology. It represents the primary social context within which an individual's personality develops and patterns of psychological and social interaction are established. From a systemic perspective, the family cannot be understood merely as a collection of individuals connected through marital or consanguineous ties; rather, it is conceptualized as a dynamic, interdependent system governed by a set of rules, boundaries, and relational structures that regulate interactions both within the family and between the family and its external environment. Furthermore, the family system organizes the roles and positions occupied by its members and shapes the patterns of interaction among them. Within this reciprocal process, each family member both influences and is influenced by the functioning and dynamics of the system as a whole.

Accordingly, the concept of the family system is grounded in General Systems Theory, which conceptualizes the family as an open system that continuously interacts with its surrounding social and cultural environment. The family system operates according to several fundamental principles, including wholeness, homeostasis, feedback, and change. Consequently, any disruption or dysfunction in the functioning of the family system may generate distress within the family and manifest in psychological and behavioral symptoms in one of its members. Such symptoms may, in turn, indicate dysfunctional patterns of interaction within the family system.

This dynamic becomes particularly significant when an older adult is part of the family, as the family serves as a primary source of psychological and social support. Such support may partially compensate for the loss of occupational and social roles that the individual previously fulfilled during earlier stages of life. Age-related changes, together with the

deterioration of certain aspects of health, may progressively compromise the older adult's functional autonomy and independence. Furthermore, the contraction of previously established social and professional networks may intensify feelings of social isolation, marginalization, and diminished self-worth.

In the absence of adequate family support, the older adult's circumstances may become increasingly challenging, potentially contributing to depressive symptoms and social withdrawal. These conditions may also increase vulnerability to the development or exacerbation of physical health problems, further compromising both psychological and physical well-being. Such circumstances may be particularly relevant to older adults residing in institutional care facilities, commonly referred to as nursing homes or residential care facilities, who live apart from their families and relatives.

The statement

The concept of the family system lies at the heart of the systemic approach, which emerged during the 1950s and is rooted in General Systems Theory, developed by the biologist Ludwig von Bertalanffy during the 1940s. This theory emphasizes that living organisms, including human social groups, should be understood as integrated wholes rather than as mere aggregates of separate and independent components. This theoretical perspective paved the way for its application to the family, particularly through the work of Gregory Bateson in the early 1950s.

Bateson's work contributed to a shift away from the traditional view of mental illness as originating solely within the individual toward an understanding that psychological disturbances may also be associated with dysfunctional patterns of interaction within the family system. In this context, the concept of transactional patterns refers to recurring patterns of interaction and communication among family members. Dysfunctional communication within these patterns may contribute to the emergence of psychological symptoms in one family member, who is referred to in family systems theory as the identified patient or symptom bearer.

This perspective also highlights the role of paradoxical communication and the double-bind phenomenon, in which an individual is exposed to contradictory messages or expectations that are difficult to reconcile. Such communication may generate confusion, uncertainty, and psychological distress, potentially contributing to frustration and depressive symptoms. In certain theoretical accounts, these interactional dynamics have also been examined in relation to schizophrenia, particularly in early family systems research. However, schizophrenia is a complex psychiatric disorder, and dysfunctional family communication should not be regarded as an established direct cause of the condition.

During the 1960s and 1970s, the concept of the family system underwent further theoretical development and gained substantial practical application with the emergence of several schools of systemic family therapy. Among the most influential figures in this field was Murray Bowen, whose contributions to multigenerational family therapy culminated in the publication of his theoretical framework in 1978. Other major approaches included Virginia Satir's experiential and communication-oriented approach to family therapy, the strategic family therapy developed by Jay Haley, and the structural family therapy established by Salvador Minuchin. These developments contributed to the consolidation of the systemic approach as a major theoretical and clinical framework in family psychology and family therapy (Albernhe, K., & Albernhe, T., 2004).

The family system exerts a significant influence on the psychological well-being of older adults. The nature of family relationships, patterns of communication, and the distribution of roles within the family all contribute to fostering a sense of security and belonging or, conversely, to intensifying feelings of social isolation and marginalization.

A supportive family system, characterized by mutual respect and the symbolic recognition of older adults' status, life experience, and accumulated wisdom, can help preserve self-esteem and reduce the likelihood of depressive and anxiety symptoms, as well as social withdrawal. Conversely, a dysfunctional family system characterized by exclusion, marginalization, or the forced reversal of family roles may exacerbate psychological distress and intensify feelings of worthlessness and loss of meaning among older adults.

Accordingly, understanding the influence of the family system on individuals during later life requires a comprehensive approach that takes into account family history, intergenerational patterns of interaction, and the symbolic significance of older adults' status and position within the family. These factors play a crucial role in promoting quality of life and preserving psychological well-being in later life.

According to Murray Bowen's Family Systems Theory, particularly his multigenerational perspective on family functioning (Bowen, 1978), unresolved family conflicts and the involuntary reversal of roles between parents and children may contribute to increased levels of anxiety and depressive symptoms among older adults within the family system. From this perspective, the older adult may become the identified patient, with their psychological symptoms reflecting broader difficulties within the family system rather than solely individual distress. In particular, depressive symptoms may be understood, within this theoretical framework, as potentially indicative of the family's difficulties in adapting to the developmental demands of later life. This stage of the family life cycle often requires a reorganization of family roles, relationships, and functional structures to accommodate the changing needs of older family members.

This new situation, for which the family may not have been adequately prepared, can further increase social isolation among older adults and lead them to withdraw from social interactions, particularly when the family environment is characterized by disintegration, internal conflict, weak emotional bonds between generations, and a lack of symbolic recognition of the older adult's role and experience within the family. Depression is therefore among the most common factors associated with emotional distress in later life and may contribute to a decline in quality of life.

Furthermore, aging involves the dynamic interaction of a range of biological, psychological, social, and economic variables that collectively influence life in later years. Among the major challenges faced by older adults are increasing physical limitations, the risk of social isolation, and economic hardship resulting from a reduced capacity to earn income. Older adults may lack the resources necessary to cope effectively with these challenges, thereby increasing their vulnerability to a range of psychological difficulties. These circumstances may also foster negative emotional states that create conditions conducive to the development of depressive disorders among older adults (Blazer, 2003).

The situation may become even more complex for older adults residing in nursing homes, where they experience social isolation away from their families. They may have been excluded from the family system or may have no immediate family members. In either case, they are deprived of a family environment. Numerous studies have reported higher rates of depression among older adults living in residential care facilities than among those living with their families. This may be associated with the disruption of contact with relatives and the perception that family members hold negative attitudes toward them. Moreover, residing in a nursing home may intensify their feelings of marginalization by society.

From a systemic perspective, when an older adult resides in a care facility while their family remains outside the institution, this situation may point to dysfunction within the family system. The family establishes the initial rules and norms that shape an individual's development, as it provides the primary relational environment from birth. It also influences the behavioral patterns individuals develop through the interactions among family members. When a family system is characterized by rigid boundaries and inflexible rules, it may become difficult to maintain the inclusion and engagement of its members. This can lead to dysfunctional interaction patterns within the family and contribute to the psychological distress experienced by one or more family members.

Furthermore, an examination of the family genogram may reveal similar interaction patterns in previous generations. From this perspective, the family may continue to reproduce these dysfunctional patterns, allowing them to persist and be transmitted across generations.

When a family is faced with the responsibility of caring for an aging member who has become entirely dependent on it, the family's response to this situation may shape how younger generations behave when confronted with similar circumstances in the future.

As individuals grow older, their health conditions may become increasingly complex, and they may experience the loss of various cognitive and motor skills, together with a decline in functional autonomy. These changes can create a need for specialized care and assistance. In families that value and respect older adults for religious and cultural reasons, and out of a sense of intergenerational loyalty, older family members may be regarded as sources of wisdom and life experience. Such families may therefore be more inclined to provide care and support. By contrast, families that perceive an older adult as a burden may resort to placing them in a residential care facility because they are unwilling or unprepared to assume responsibility for their care. This may occur despite the fact that the older adult helped establish the family during their younger years and contributed to its development throughout adulthood. Consequently, the older person may experience a profound sense of abandonment when the family they helped build appears to turn away from them, placing them in a residential care facility and leaving them there with little or no prospect of returning home.

This separation can abruptly sever the older adult's everyday interactions with family members whom they have loved, whose births they have witnessed, and whose lives they have accompanied as they grew into adulthood. The older person may subsequently experience rejection and exclusion from the warmth of the very family they helped establish. Such a rupture in family relationships may indicate dysfunction within the family system.

From a systemic perspective, the source of this dysfunction may lie partly in the behavior of a second-generation family member who exerts pressure on the family and prevents other members from expressing negative emotions, particularly in their presence. This dynamic may intensify the crisis experienced by the identified patient—in this case, the older adult, who is exposed to contradictory and double-bind interactional patterns. Such interactions may reinforce feelings of inferiority, marginalization, and being unwanted within a dysfunctional family system.

This situation may also be understood through the systemic concept of family myths (*mythes familiaux*), whereby family members implicitly share assumptions and beliefs that help preserve the family's established balance. In some dysfunctional systems, these implicit agreements may result in the exclusion of one family member as a means of maintaining family homeostasis. In the situation under consideration, the older adult may become the person excluded from the family system.

This exclusion may intensify feelings of sadness and emotional pain and contribute to the development of depression and hopelessness, potentially leading to a diminished desire to live. Alternatively, the older adult may seek to leave the family environment they perceive as rejecting and choose to live apart from their relatives, alone and overwhelmed by sadness and depressive feelings. The situation may deteriorate further if the older adult does not receive adequate psychological and medical care from the professionals responsible for their well-being in the residential facility. Although such facilities can provide essential care and support, they may not fully replace the emotional warmth of family life, the sharing of joys and sorrows, and the sense of belonging that comes from remaining connected to loved ones.

The question

Is the family system characterized by dysfunction, as perceived by the depressed older adult?

Hypothesis

The hypothesis posits that family dysfunction, as perceived by the older adult and assessed using the Family Assessment Test (FAT), contributes to the depressive symptoms experienced by older adults residing in residential care facilities.

3 Definition of the Study Terms

3.1. Family System

The concept of the family system refers to a group of individuals engaged in continuous interaction, in which relationships among members remain relatively stable over a given period of time (Mark, E., & Picard, D., 1984, p. 27).

3.2. Depression Among Older Adults Residing in Residential Care Facilities

According to the World Health Organization (WHO, 2025), depression is a mental health condition characterized by depressed mood and a persistent loss of interest or pleasure. Among older adults, particularly those residing in residential care facilities, depressive symptoms may be associated with institutional residence itself, loss of independence, social isolation, and separation from the family environment. These factors may contribute to the emergence of depressive symptoms, which can manifest in somatic forms, such as pain or digestive disturbances, as well as through tension, irritability, or feelings of weakness, without the individual necessarily expressing feelings of sadness or depression directly.

According to the World Health Organization, depression among older adults residing in residential care facilities often goes undiagnosed because it may be mistakenly regarded as a normal part of aging or attributed to other chronic medical conditions. The WHO has also promoted initiatives aimed at improving the health and well-being of older adults, including the Decade of Healthy Ageing initiative.

Methodology

This study adopted the clinical approach, using the case study method, as it is well suited to the subject under investigation, which focuses specifically on the psychology of older adults and the challenging stage of life they experience. This stage is often accompanied by a decline in cognitive, sensory, motor, and functional abilities, as well as a reduction in financial resources, all of which may further complicate their circumstances.

Accordingly, this study focused on the case of an older man, referred to by the pseudonym “Mr. Majid,” aged 70, who was residing in a residential care facility for older adults in Algiers, Algeria. At the time of the interview, he had been living at the facility for two years. Family conflicts and ongoing problems had compelled him to leave his home and move to the residential care facility, not out of his own free choice, but under duress, in an attempt to avoid a situation that might otherwise have escalated into more severe circumstances.

This case was selected following a review of his medical records, which indicated that he had been diagnosed with severe depression upon his initial admission to the facility. This diagnosis prompted the facility’s staff to refer him for therapeutic sessions with the resident psychologist, with the aim of alleviating the severity of his depressive symptoms, the most prominent of which included:

- ✓ Social withdrawal from other residents and a preference for remaining alone.
- ✓ Episodes of crying in private, accompanied by visible sadness and hopelessness.
- ✓ No participation in activities with others.
- ✓ Refusal to speak, a diminished desire to live, lack of interest in anything, and loss of pleasure.
- ✓ Spending most of his time lying in bed.

Study Instruments

The study instruments comprise the following:

5.1. Clinical Interview with the Older Adult

In systemic-oriented clinical interviewing, whether for diagnostic or therapeutic purposes, the primary concern is to identify how the family system functions and how the individual, couple, or family interacts within it, as well as to uncover dysfunctional and deadlocked interactional patterns that are difficult to overcome.

These patterns of interaction are internalized over a long period, often unconsciously, and family members continue to interact according to them. Such patterns are governed by what is referred to as “covert loyalty” (loyauté secrète) and “family myths” (les mythes familiaux). These dynamics may prevent family members from escaping a conflictual situation without intervention through systemic family therapy (Chiland, C., 1989).

When the older adult becomes the identified patient within a dysfunctional family system, they may be subjected to various forms of negative projection by family members who form an alliance against them, seeking to exclude them from the family system in an attempt to restore and maintain family homeostasis. This equilibrium may have been disrupted by the emergence of new demands associated with the individual’s advancing age and need for specialized care. The family may be unprepared for this sudden change, which may be understood as a first-order change within the system, particularly when similar situations have not previously been transmitted across generations. Alternatively, a second-order change may occur within the intergenerational family system, whereby the older adult is abandoned and isolated from the family through placement in a residential care facility for older adults.

Therefore, conducting a clinical interview with an older adult who has been excluded from the family and resides in a residential care facility for older adults requires a sensitive and individualized approach that takes into account both the person’s age and the psychological distress experienced as a result of social and familial isolation. Such experiences may leave psychological scars that compound the limitations the older adult faces across multiple domains of functioning.

Accordingly, the clinical interview in this study will focus on examining indicators of family-system functioning and dysfunction as perceived by the older adult residing in the care facility. The main indicators guiding the clinical interview for the purposes of this study are organized around the following domains:

- How would you describe your relationship with your family before retirement?
- How would you describe the members of your family?
- How did you feel within your family?
- What were the main issues on which you and your family agreed?
- What were the main issues on which you and your family disagreed?
- How did your family members treat you when you reached retirement age?
- How was the decision made for you to move into the residential care facility for older adults?
- How would you describe your relationship with your family since moving into the residential care facility for older adults?

5.2. The Family Apperception Test (FAT)

The Family Apperception Test (FAT) is a projective assessment instrument developed in 1999 by Julia III, Wayne M. Sotile, Susan E. Henry, and Mary O. Sotile. It is one of the few instruments used in clinical practice for both individual and family assessment in the field of mental health, particularly in the development of therapeutic programs that take the characteristics and functioning of the family system into consideration.

The Family Apperception Test (FAT) consists of 21 picture cards and a scoring sheet used to calculate the Family Dysfunction Index. The cards depict common social and family situations and activities, designed to elicit projective responses concerning family contexts and structures, as well as emotional responses associated with family interactions in specific situations (Wayne et al., 1999).

Each picture card depicts a specific issue, as illustrated in the following table:

Table 1. Issues Depicted in the FAT Pictures

Picture 1	Picture 2	Picture 3	Picture 4	Picture 5	Picture 6	Picture 7
Dinner	The sound	Punishment	Clothing store	Living room	Putting away	Upstairs
Picture 8	Picture 9	Picture 10	Picture 11	Picture 12	Picture 13	Picture 14
shopping	kitchen	Baseball	Lateness	Schoolwork	Bedtime	Playing tag
Picture 15	Picture 16	Picture 17	Picture 18	Picture 19	Picture 20	Picture 21
Game	Keys	Makeup	Trip	Office	Mirror	Embrace

Scoring the Family Apperception Test (FAT)

The analysis of the results obtained from administering the FAT is based on the extent to which the responses meet specific criteria that enable the eight questions to be answered, as illustrated in the following table:

Table 2. The Eight Guidelines for Analyzing the FAT Protocol (FAT, 1999)

	Guides
I	Is the protocol sufficiently extensive to allow the formulation of valid working hypotheses?
II	Is there evidence of conflict?
III	In which domain does the conflict manifest itself?
IV	What is this family's pattern of functioning?
V	What hypotheses can be formulated regarding the nature of the relationships observed within the family?
VI	What hypotheses can be formulated regarding the nature of the relationships observed within the family?
VII	Are there indicators of severe maladjustment?
VIII	Does the protocol contain themes that contribute to the formulation of clinically meaningful hypotheses?

Case Presentation Mr. Majid

Mr. Majid is a 70-year-old man, was married for 33 years and had three children: a son, who is married, has three daughters, and lives with him, and two daughters who are married and have moved abroad to live in different countries. His wife passed away two years ago, and he was deeply affected by her loss.

Approximately five years later, Mr. Majid began experiencing increasing difficulties with mobility and walking. He eventually required a cane for support, while more pronounced signs of ageing became apparent. His movements became increasingly difficult, and he sometimes required assistance with certain daily activities, reflecting a gradual loss of independence.

His daughter-in-law was unwilling to assume responsibility for his care, which led to growing conflict between the couple. Consequently, Mr. Majid decided to leave the family home and move into a residential care facility for older adults. He chose to distance himself from his family and withdraw from the family system in an attempt to put an end to the ongoing conflict.

Following his admission to the care facility, Mr. Majid became socially withdrawn, interacted very little with the other residents, and developed severe depressive symptoms. His condition required medical intervention, including the prescription of antidepressant medication.

During the clinical interview, Mr. Majid presented with a sad facial expression and spoke with difficulty. He expressed profound distress over his separation from his son and the prospect of living apart from his family.

The genogram of Mr Majid

According to the principles of general systems theory, particularly those pertaining to natural and living systems, the family system is considered one of the most complex and influential systems, as it relies on highly intricate patterns of interactional communication. These patterns unfold through sequential contexts that are recorded along a linear timeline and extend across generations.

To understand these successive interactional patterns, pioneers of the family systems approach developed a diagrammatic method for representing the family tree, known as the genogram. This tool facilitates the understanding of relationships between family members and the interactional patterns that govern the functioning of the family system.

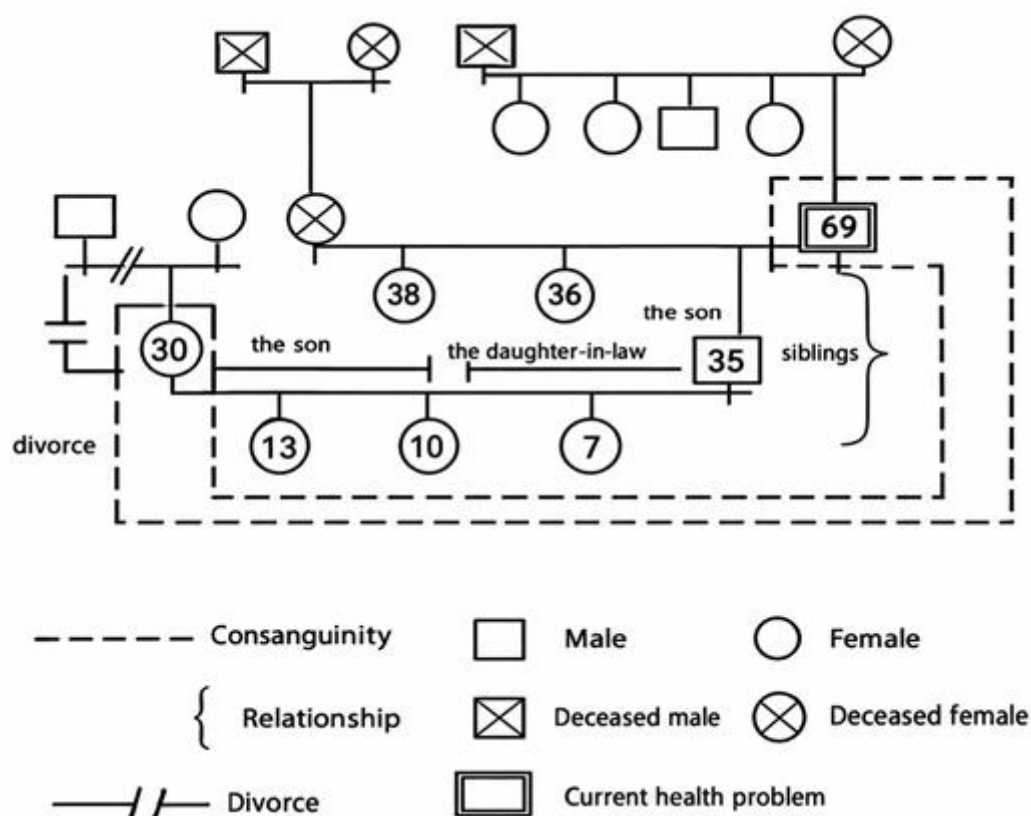
The development of this approach is attributed to McGoldrick, Gerson, and Shellenberger (1999), who drew upon concepts introduced by Murray Bowen in his comprehensive theory of family therapy, known as intergenerational family therapy (Albernh, K., & Albernh, T., 2004).

This diagrammatic representation of the family tree, known as a genogram, makes it possible to explore the internal psychological dynamics of the family system and conduct a multi generational assessment by documenting significant events that affect the family system and are transmitted across generations. Particular attention is given to emotional experiences and their intergenerational transmission. Explaining these patterns to family members helps them understand the dynamics underlying their current situation, identify relational impasses, and bring about changes in dysfunctional patterns of interaction among family members. These patterns are shaped by the ties that bind individuals together, including blood relationships, kinship, emotional bonds, and various obligations.

Within the family, one or more members may become the **identified patient** or symptom bearer, sometimes assuming this role in ways that contribute to the preservation of family homeostasis at the expense of the most vulnerable, fragile, or submissive members. This dynamic is illustrated by the case of Mr. Majid, who came to occupy the role of the “scapegoat” in an effort to preserve the equilibrium of the family subsystem comprising his son, daughter-in-law, and granddaughters.

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Figure 1. Genogram of Mr. Majid's Family



According to Mr. Majid's genogram, the dysfunctional interactional pattern appears to have emerged in relation to his daughter-in-law. The genogram indicates that she had previously experienced conflict with her father. According to Mr. Majid, she was her father's only daughter and continued to live with him following her parents' divorce. From an early age, during adolescence, she assumed responsibility for caring for her father and meeting his needs. This situation prevented her from pursuing her education, as her father compelled her to remain at home until she married.

It appears that this dysfunctional relationship with her strict father, together with the deprivation of educational opportunities and the obligation to remain at home to care for him, may have contributed to the repetition of this painful experience in her relationship with her father-in-law. The conflict was subsequently transferred into her marital family, initially involving Mr. Majid, her father-in-law, and extending to attempts to exert control over her husband. Ultimately, this situation resulted in her temporary withdrawal from the family system and her separation from her daughters.

On the other hand, Mr. Majid's son is described as defending his father and forming an alliance with him against his wife. He does not accept his father's exclusion from the primary family subsystem. Consequently, the daughter-in-law may be understood, within this systemic interpretation, as a source of pressure and as a carrier of conflictual interactional patterns that contributed to disrupting family-system functioning.

These dynamics may have contributed to the emergence or exacerbation of Mr. Majid's depressive symptoms, in addition to the grief and sadness he experienced following the death of his wife, to whom he had been deeply attached. He thus found himself confronting another significant loss: separation from his son and the family he had established. Faced with this situation, he felt compelled to withdraw from the family system and move into a residential care facility for older adults.

His departure made it possible for his daughter-in-law to return to the family subsystem, resume living with her husband, and reunite with her daughters, allowing them to continue living together under one roof. In this interpretation, the re-establishment of the younger family unit occurred at the expense of the older adult, who had come to be perceived as a burden on his family. Mr. Majid therefore decided to leave, carrying with him his grief and disappointment toward the family he had helped establish.

Results of the Family Apperception Test (FAT)

Following the administration of the Family Apperception Test (FAT) to Mr. Majid, the protocol was evaluated according to the eight guidelines. The results indicated that the protocol was suitable for analysis and for conducting a clinical interpretation of indicators of family-system functioning as perceived by Mr. Majid. The main findings were as follows:

1-Clarity and adequacy of the narratives: The stories elicited by the picture cards were clear and sufficiently detailed to allow the analysis to be completed.

2-Family Dysfunction Index: The Family Dysfunction Index, reflecting Mr. Majid's perception of family-system functioning, was relatively high, with a score of 56. This result suggests that, from his perspective, the family conflict remained unresolved.

3-Nature of the conflict: Most of the conflicts were family-related. The daughter-in-law appeared in several narratives as a source of tension and pressure within the family system.

4- Parental maturity: The protocol indicated difficulties relating to parental maturity in both the son and his wife.

5-Quality of family relationships and intergenerational boundaries: The indicators concerning the quality of family relationships suggested the presence of overlapping conflicts and unclear boundaries between generations. These findings may indicate difficulties in preparing family members to cope with comparable social situations, particularly those arising when an older family member's needs change within the family. They also suggest difficulties in adapting to the new circumstances associated with ageing and grandparenthood, including declines in health, cognitive and motor functioning, and financial income.

6-We hypothesize that, although Mr. Majid's son was already married, family conflict did not become apparent until Mr. Majid advanced in age and became less able to contribute to the management of household and family affairs. This situation was compounded by the premature loss of his wife, to whom he had been deeply attached, leaving him with a profound emotional void and a heightened sense of loneliness.

His daughter-in-law may have exerted indirect pressure on him by repeatedly engaging in conflicts with her husband over her perceived inability to manage household responsibilities and care for the children while also having to accommodate the needs of her elderly father-in-law. These circumstances may have intensified Mr. Majid's feelings of rejection and of being unwanted within the family. He came to perceive that his daughter-in-law wished to exclude him from the family environment through various means.

7. Indicators of Maltreatment and Psychological Distress

Across several picture-card narratives, the protocol revealed responses associated with maltreatment, expressions of pressure and conflict, and the evocation of negative emotions, particularly sadness and anger. It also contained references to illness and physical incapacity, accompanied by depressive expressions, stammering, and difficulties in verbal expression.

8. Clinical Recommendations

In light of the indicators outlined above, we consider clinical intervention to be necessary in Mr. Majid's case. We therefore recommend that the family be encouraged to seek family therapy, particularly intergenerational family therapy based on Murray Bowen's **approach**. The aim would be to facilitate Mr. Majid's reintegration into family life and help him regain his place within his family and, potentially, his former home, which holds many memories of his life with his wife and children.

Such an intervention could help address his feelings of loneliness, depressive distress, social isolation, and perceived familial rejection. It could also support the restoration of his role as an affectionate grandfather who shares a close emotional bond with his granddaughters.

The protocol obtained from Mr. Majid's administration of the Family Apperception Test (FAT) was characterized by a very high Family Dysfunction Index, with a score of 52. This score was primarily attributable to the intensity of conflictual dynamics within the family (Conflict Index = 4), alongside the couple's inability to identify appropriate solutions to resolve the relational impasse. Consequently, Mr. Majid tended to reproduce almost identical scenarios across most of the picture cards, as reflected in the Dysfunctional Circulation Index (= 4). This pattern suggests the persistence of family dysfunction as perceived by Mr. Majid through the FAT protocol.

The mother was perceived as a source of tension in most of the picture cards, reinforcing the presence of marital conflict that extended into broader family conflict and conflict involving the children. These dynamics contributed to increasing emotional distance among family members and, at times, to confrontations that culminated in anger and aggressive behaviour (Aggression Index = 3).

The protocol also revealed numerous negative emotional expressions within the family, including anxiety and fear (Index = 4), as well as depression and sadness (Index = 4) experienced by the grandfather. His daughter-in-law was unwilling to accept his presence and refused to devote herself to caring for him, despite having spent her own adolescence and early adulthood caring for her father.

Consequently, the family appeared to be characterized by confusion and ambiguity in the management and expression of emotions, together with the avoidance of direct communication. Rather than confronting her father-in-law directly, the daughter-in-law reportedly directed her anger and resentment towards her husband and daughters. This pattern contributed to increasing emotional distance among family members and led to a temporary separation between the spouses, reflecting their difficulty in managing the situation of an ageing member of the primary family subsystem who required care, affection, and family support.

Mr. Majid thus becomes the **identified patient** or symptom bearer, bearing the consequences of an interactional pattern introduced by his daughter-in-law. This pattern appears to have been internalized and may be transmitted to her children, either consciously or unconsciously. Nevertheless, it can be interpreted as a dysfunctional pattern that disrupts the functioning of the family subsystem and the broader family system.

From a systemic family therapy perspective, intervention would therefore seek to address the daughter-in-law's interactional behaviour, given her role as a source of tension and relational dysfunction within the family. At the same time, she may herself be understood as a vulnerable member who carries unresolved difficulties originating in her family of origin, which was disrupted by her parents' divorce. Following the separation, she appears to have been placed in the position of a substitute for her absent mother, assuming responsibility for caring for her father and meeting his needs.

This history may represent an important indicator of family dysfunction, particularly when the family hierarchy becomes disrupted, generational boundaries become blurred, and roles and positions are reversed. These interactional patterns subsequently manifested in depressive themes, negative emotions, and feelings of hopelessness, seemingly extending from the daughter-in-law's family of origin into Mr. Majid's family system. This repetitive and self-perpetuating cycle resembles what systemic therapists refer to as a "game without end"

Over time, these dynamics may have contributed to the erosion of boundaries and increasing emotional distance among members of Mr. Majid's family. This represents a significant departure from the cohesion, solidarity, care, and affection that had previously characterized the family he established with his late wife and their children.

Conclusion

The concept of the system in the psychological and social sciences has introduced a new approach to understanding psychological and social disorders. From this perspective, a system is understood as an integrated whole composed of interconnected parts that operate according to the principle of a unified outcome. Similarly, the family system is not merely an aggregation of individual elements or components; rather, it consists of a group of individuals, each with a specific role and status, who interact with one another and are connected through bonds of blood, kinship, and a shared destiny.

Any dysfunction in the family system may indicate the presence of a dysfunctional interactional pattern within the family, which may become manifest through one of its members, who assumes the role of the identified patient or symptom bearer. The symptom is understood, within this theoretical perspective, as an expression of communication dysfunction within the family system.

Such dysfunction may involve contradictions between two opposing levels of communication, affecting one or more family members. Gregory Bateson (Bateson, G.) referred to this phenomenon as the double bind. It arises when an individual receives a message that conveys two contradictory contexts simultaneously, creating ambiguity and making it difficult for the individual to distinguish between the two messages and, consequently, to understand the intended meaning. According to the systemic theorists who developed this concept, such a situation may engender feelings of helplessness and confusion and was historically proposed as a factor contributing to the development of schizophrenia.

Accordingly, the systemic approach, together with the various forms of family therapy it proposes in response to the dysfunctional patterns affecting the family system, offers a framework for observing and understanding family-system functioning. This can be achieved through the use of technical tools such as the genogram, which provides a visual representation of interactional patterns within the family, helps identify relational configurations such as alliances, and facilitates the identification of family members who are more directly involved in the emergence or maintenance of dysfunctional patterns.

The genogram can also help reveal concealed interactional patterns transmitted across generations under the guise of "covert loyalty" or what are known as "family myths." These patterns may be transmitted unconsciously, having become established and perpetuated from one generation to the next, making them difficult to change without systemic family therapy. From this perspective, the emergence of psychological symptoms in an individual is understood in relation to communication dysfunction within the family as a whole, while the identified patient is regarded not simply as the source of the problem, but as a possible indicator of dysfunction in the functioning of the family system.

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