FAMILY GRIEF THERAPY: A PRELIMINARY ACCOUNT OF A NEW MODEL TO PROMOTE HEALTHY FAMILY FUNCTIONING DURING PALLIATIVE CARE AND BEREAVENTMENT

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SUMMARY
The family is usually the primary provider of care for the terminally ill patient with cancer or other serious progressive illness. The way in which such a family functions is a major determinant of psychological well-being for its members. Through screening with the Family Relationships Index (FRI) (Moos and Moos, 1981), dysfunctional families and those at risk can be identified, and then helped to achieve better family functioning, thus improving psychosocial outcome of their grief. In this paper, we describe the techniques and themes involved in the application of our empirically developed model of family grief therapy, designed as a preventive intervention for use in the setting of palliative care and bereavement. © 1998 John Wiley & Sons, Ltd.

INTRODUCTION
A progressive serious illness inevitably involves the patient’s family in a care-providing role and eventually leaves them to cope with their loss and experience of bereavement. A focus on the family’s needs is thus an appropriate aspect of palliative care (Northouse, 1984; Rait and Lederberg, 1989; Bluglass, 1991). A review of clinical and research studies on the bereaved family points to different patterns of family responses (Kissane and Bloch, 1994); in broad terms, these are adaptive or maladaptive, the latter including avoidance of grief, its distortion (e.g. anger, blame or idealization of the deceased), rigidity or overwhelming intensity (Kissane, 1994).

Given this dichotomy, we set out to delineate types of family grief with the aims of identifying those at risk of a poor psychosocial outcome and devising a corresponding model of intervention to avoid or lessen this risk. In particular, we confirmed the relationship between the nature of family functioning and psychosocial wellbeing during palliative care, dysfunctional families carrying greater morbidity within their membership (Kissane et al., 1994a). We sought patterns through cluster analysis (Wallace and Boulton, 1968; Wallace and Freeman, 1992) with the aim of identifying those at risk of a poor psychosocial outcome. Dimensions of cohesiveness, level of conflict and expressiveness of thought and feeling, derived from the Family Environment Scale (FES) (Moos and Moos, 1981), emerged as the cardinal features of five types of family in our first cohort of 102 families in which an ill member was receiving palliative care (Kissane et al., 1994b). We repeated this cluster analytic approach with a further cohort of 115 bereaved families (Kissane et al., 1996a,b). Our classification was both consistent over time and facilitated the prediction of psychological outcome.

We named our five classes of families with the following descriptors: supportive, conflict-resolving, intermediate, sullen and hostile. Half of the families were well-functioning, either supportive, through enjoying high cohesiveness, minimal conflict and open expressiveness, or conflict-resolving, that is, evidently able to handle conflict effectively by dint of their expressiveness and cohesion. Grief waned over the 13 months in these families; moreover, their overall psychoso-
Table 1. Comparison of Family Environment Scale scores of respondents in five family types

<table>
<thead>
<tr>
<th>Family types (through Cluster Analysis)</th>
<th>Supportive</th>
<th>Conflict-resolving</th>
<th>Intermediate</th>
<th>Sullen</th>
<th>Hostile</th>
<th>Analysis of variance F, p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative care families 1994b (102 families, 342 members)</td>
<td>Cohesiveness (max score 4)</td>
<td>4.0 (0.0)</td>
<td>4.0 (0.0)</td>
<td>3.0 (0.0)</td>
<td>2.0 (0.2)</td>
<td>0.7 (0.6)</td>
</tr>
<tr>
<td></td>
<td>Conflict (max score 4)</td>
<td>0.0 (0.0)</td>
<td>1.9 (0.8)</td>
<td>1.0 (1.1)</td>
<td>1.3 (1.3)</td>
<td>2.7 (1.6)</td>
</tr>
<tr>
<td></td>
<td>Expressiveness (max score 4)</td>
<td>2.6 (1.1)</td>
<td>2.3 (1.1)</td>
<td>1.9 (1.1)</td>
<td>1.7 (1.1)</td>
<td>0.6 (0.6)</td>
</tr>
<tr>
<td></td>
<td>Family Relationships Index (max score 12)</td>
<td>10.6 (1.1)</td>
<td>8.4 (1.3)</td>
<td>7.9 (1.7)</td>
<td>6.4 (1.8)</td>
<td>2.6 (1.9)</td>
</tr>
<tr>
<td>Bereaved families 1996c (115 families, 253 members)</td>
<td>Cohesiveness (max score 4)</td>
<td>4.0 (0.3)</td>
<td>4.0 (0.3)</td>
<td>3.0 (0.2)</td>
<td>3.0 (0.3)</td>
<td>1.4 (0.7)</td>
</tr>
<tr>
<td></td>
<td>Conflict (max score 4)</td>
<td>0.0 (0.3)</td>
<td>1.6 (0.7)</td>
<td>0.0 (0.3)</td>
<td>1.9 (1.0)</td>
<td>1.8 (1.4)</td>
</tr>
<tr>
<td></td>
<td>Expressiveness (max score 4)</td>
<td>2.4 (1.2)</td>
<td>2.6 (1.2)</td>
<td>2.4 (1.0)</td>
<td>2.1 (1.1)</td>
<td>1.0 (0.9)</td>
</tr>
<tr>
<td></td>
<td>Family Relationships Index (max score 12)</td>
<td>10.5 (1.2)</td>
<td>9.0 (1.4)</td>
<td>9.4 (1.0)</td>
<td>7.2 (1.4)</td>
<td>4.6 (2.1)</td>
</tr>
</tbody>
</table>

*Mean (SD); b adapted with permission from Psycho-Oncology; c adapted with permission from American Journal of Psychiatry.

Social outcomes were good. By contrast, a third of the families were either hostile, distinguished by high conflict, low cohesiveness and poor expressiveness, or sullen, with moderate levels in these three domains. Their outcome was poor—sullen families reported high rates of depression, while hostile families were particularly fractured and chaotic in their adaptation. Intermediate families, a fifth of the sample, exhibited moderate cohesiveness, but were still prone to psychosocial morbidity.

To illustrate the pattern of family functioning found in these five classes of families, scores from our studies for subscales of the FES have been reproduced in Table 1. Cohesiveness is the major determinant of the typology and any reduction in its score becomes our first marker of concern for the index family. Our other rules for recognition via screening of at risk families are set out in Table 2. Well-functioning families (supportive and conflict-resolving) display high cohesiveness (i.e. score 4 out of maximum 4) and an FRI greater than 9. Dysfunctional families (hostile and sullen) and those with intermediate functioning demonstrate reduced cohesiveness (score less than 4) or an FRI equal to or less than 9. Utilising this approach, we have employed the FRI (12 items) as a screening instrument (see Table 3) to identify families of concern that we seek to work with preventively to enhance their well-being.

Secondly, we attempt to understand what the major ‘family environment’ is, through inspection of all available scores in order to discern which aspect is particularly problematic, e.g. cohesion, level of conflict or expressiveness. On the other hand, we do not consider family mean scores at all, since such an approach would eliminate some of the more subtle aspects of family functioning. In our previous studies, our cluster analytic approach was based on individual perceptions of family members, but a subsequent hierarchical analysis, taking the family as the unit of analysis,
Table 2. Screening rules utilising the Family Relationships Index (FRI) of the FES to identify those palliative care families deemed at risk of maladaptive outcome on the basis of their family functioning

A. Well-functioning families (low risk)
   Cohesiveness score 4 (out of max 4) plus FRI > 9 (out of max 12)

B. Families considered at some risk
   Cohesiveness score < 4 or FRI < 9

FES subscales       Typical range of scores for family types
                   Intermediate Sullen Hostile
Cohesiveness        3–4  2–3  0–2
Expressiveness       1–3  1–2  0–2
Conflict             0–1  1–2  1–4
FRI                  7–9  6–7  0–4

FRI is the sum of the scores for cohesiveness, expressiveness and the reversed conflict score out of 4. Within well-functioning families, conflict-resolving are not routinely separated from supportive families, but the latter have no conflict, and both types carry cohesiveness scores of 4.0.

confirmed the validity of our typology (Kissane et al., 1996a,b). We prefer to base assessment on perceptions of individuals as this permits recognition of family ‘symptom bearers’ or ‘scapegoats’, whose perspective might be overlooked if mean scores were used. Naturally, the perceptions of individual family members do vary, in which event, for classification purposes, we adopt the dominant family pattern.

With this typology of family functioning, we fulfilled our aim of having the means to identify families (hostile, sullen and intermediate) at risk of a poor outcome in the setting of palliative care. The corollary was whether a preventive family approach could be adopted to minimize this psychosocial morbidity. Following literature review and an in depth ‘brain storm’ of how to meet the needs of at risk families, we piloted therapy with 15 such families with the goal of improving their functioning. In the process we devised a manual, basically a guide to the entire process, including the recruitment of relevant family members, establishing rapport, sustaining the focus and preparing for termination. We systematically observed its application by a small team of therapists. In this paper, we describe the model as it has emerged from such piloting. We are now conducting a major randomized, controlled trial with 100 families in order to confirm its effectiveness.

A MODEL OF FAMILY GRIEF THERAPY

Our description of the model covers goals, family selection, membership, therapists, preparation and

Table 3. The Family Relationships Index (Moos and Moos, 1981) used for screening families

<table>
<thead>
<tr>
<th>Statement</th>
<th>TRUE</th>
<th>FALSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family members really help and support one another</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>2. Family members often keep their feelings to themselves</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>3. We fight a lot in our family</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>4. We often seem to be killing time at home</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>5. We say anything we want to around the home</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>6. Family members rarely become openly angry</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>7. We put a lot of energy into what we do at home</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>8. It is hard to ‘blow off steam’ at home without upsetting somebody</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>9. Family members sometimes get so angry they throw things</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>10. There is a feeling of togetherness in our family</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>11. We tell each other about our personal problems</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>12. Family members hardly ever lose their tempers</td>
<td>True</td>
<td>False</td>
</tr>
</tbody>
</table>

Scoring Rules: Cohesiveness = 1True + 4False + 7True + 10False; Expressiveness = 2False + 5True + 8False + 11True; Conflict = 3True + 6False + 9True + 12False; FRI = cohesiveness + expressiveness + reversed (out of 4) conflict scores.

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course of the therapy, which progresses through assessment, the focus on family functioning, recognition of common themes that also typically arise, and termination. We describe examples of families from our pilot phase.

**Goals of therapy**

To fulfill the goal of improving family adjustment during palliative care and associated bereavement, we opted to concentrate on enhancing family functioning, particularly cohesiveness, conflict resolution and expression of thoughts and feelings. We also wished to promote the family’s sharing of grief, their recognition of customary patterns of relating and coping, and their capacity to explore and wrestle with any specific concerns or problems.

Given these objectives, we adopted a focused, time-limited therapy that could harness the members’ strengths so as to empower them to face the challenge of relevant change, while at the same time accepting the limits of the exercise by not getting drawn into overambitious work or delving into long-standing personality problems.

**Selection by screening**

Extrapolating from our research findings, approximately half of the families in our community have the ability to adapt effectively to the illness and death of one of their adult members (Kissane et al., 1994b, 1996a,b); we see it as appropriate therefore to target only those families at risk of a poor outcome. These are the families previously described as hostile, sullen or intermediate. In clinical work, we would advocate routine screening, since it is straightforward to apply and only minimally intrusive.

To screen, we use the FRI (see Table 3), derived from the short form of the FES (Moos and Moos, 1981), a well-validated, self-report questionnaire whose predictive capacity has been supported by its use in extensive research (Moos, 1990). All nuclear family members are invited to complete the instrument, including children above age 12. A family is deemed at risk if one or more respondents score 9 or less out of 12, or less than 4 on cohesiveness, the latter because reduced cohesiveness is the most sensitive predictor of poor outcome in our model (see Table 2).

**Membership of the family**

If the FRI pattern points to vulnerability, all members of the patient’s immediate family are invited to attend, including the dying patient. In practice, the family determines who participates and we work with whatever configuration we can access (on occasion, encouraging absentees, usually one or more children, to join in at a later stage). However, we stress the potential benefit in hearing the view of every family member and welcome involvement of significant relatives (such as sons- or daughters-in-law). Sometimes, a key member may elect not to attend; we then draw confidence from the knowledge that has accumulated in family therapy that change in one part of the family system is likely to influence others and that benefits tend to percolate throughout the system (Hoffman, 1981; Selvini Palazzoli, 1983; Campbell et al., 1991).

**Therapists**

We recruit therapists from the mental health profession who are acquainted with a systems approach, more commonly social workers. A detailed set of guidelines has been developed to facilitate mastering the model as well as to ensure uniformity (this manual is available from the authors). Therapists are trained in a series of workshops, followed by weekly supervision, utilising a peer group model. They continue to meet weekly in group supervision after the set training program has ended, in the interest of sharing their growing experience with one another, and of obtaining feedback for complex issues arising in therapy.

Each therapist works individually. Sessions are audio-taped for research purposes, and the material summarized as process notes so that the thoughts and reactions of the therapist during the session may be readily shared in supervision.

**Preparing the family for therapy**

Since families are recruited as part of a research study by our program co-ordinator (M. McK.) who screens, obtains informed consent from each member, conducts a preliminary assessment and then arranges for an independent randomization, members need comprehensive preparation for the task ahead. We inform them of our research
interest in working with a variety of families; at no stage are they labeled as pathological or dysfunctional. We indicate that in our experience families are apt to benefit if they come together to explore and review members’ concerns about their ill relative and about the group as a whole. The coordinator links family and therapist, scheduling the first session.

The course of therapy

Therapy progresses through five sequential phases: assessment, identification of relevant issues emerging from the initial phase, focused treatment, consolidation and ending. During the assessment, the therapist actively promotes self-disclosure, expression and sharing of concerns and an understanding of the illness and its likely course. Traditional family patterns of grief and coping are clarified as a detailed family genogram is constructed. Grief is supported as treatment evolves, and aspects of family functioning about which the family has shared concern are highlighted. Adaptive solutions adopted by the family are affirmed and encouraged from the outset. Open, honest communication, altruism and mutual support are promoted and reinforced. The consolidation phase sees further clarification of desirable family functioning, a process emphasized iteratively as the pathway to improved well-being for all the participants.

By launching therapy during palliative care, we work to forge a therapeutic alliance with the family in order to enhance its functioning before the death of its ill member. Therapy then continues during the bereavement phase. In general, we allocate the first two sessions for assessment, two to four sessions to the treatment phase and one to two sessions for consolidation and ending. The program therefore runs for six to eight sessions, usually extending across 6 or more months. A typical session lasts 1.5 h.

The frequency of sessions is flexible and determined in conjunction with the family, varying from weekly during assessment, to fortnightly or monthly during treatment, and every two or three monthly to consolidate. When a therapist recognizes sustained improvement in conjunction with the family, a joint agreement to end is made; this incorporates a review of their experience and an affirmation of what has been accomplished.

The assessment phase

After the family and the therapist introduce themselves, members are invited to share their story of the illness and its effects on themselves. As this narrative unfolds, the therapist seeks to clarify the roles occupied by all members (e.g. providing care for the ill relative) and to understand the interactions between them. Data gathering moves beyond historical material to the exploration of family function. Who talks to whom about the illness? How do they communicate as a family? Whom do patient and spouse experience as supportive? How emotionally involved are members with one another? How do they respond to various concerns expressed by members? How does the family try to resolve particular concerns? Are there rules to which the members adhere?

During the second session, a genogram is routinely drawn to identify the family structure and patterns of relating across generations. Previous occasions of loss and bereavement are closely considered with an emphasis on customary coping patterns.

Towards the end of the assessment, the family are encouraged to prioritize their primary concerns. This important step facilitates the family assuming some of the responsibility for aspects they would like to change. The ‘ownership’ of such a list of concerns is the key to the therapist then inviting the family to return for further sessions. Achieving consensus at this point ensures focusing on relevant dimensions of family functioning in the context of the three basic goals of promoting cohesiveness, expression of thoughts and feelings, and effective conflict management.

Throughout the assessment, the therapist takes care to avoid acting judgementally or critically. She also strenuously avoids ‘siding’ with particular family members. Moreover, the strengths and assets of the family are ‘celebrated’ and affirmed. This leads to the balanced position in which the therapist can endorse any strengths and assets as a potential means to grapple with identified concerns.

The focused treatment

As each session begins, the therapist reviews the family’s state of well-being and any progress
attained. Affirmation of any improvement is a core feature of this review, since it serves to reinforce the family’s effort and confirms the benefits of greater sharing of thoughts and feelings. The therapist also invites the family to consider the advantages of any growing cohesiveness.

‘Problem solving’ is one basic technique that may pave the way for enhanced family functioning. As issues are grappled with, their antecedents and consequences are clarified, as are available options to deal effectively with them. The therapist helps members to arrive at preferred solutions, but without imposing her own. The family becomes increasingly adept at understanding its own functioning and empowered to make choices that previously were not apparent to it.

Resolving conflict-laden issues is more demanding and challenging for families where long established resentment dominates interactions. A pattern of relating may have been transmitted from generation to generation, determined by an entrenched ‘script’ (Byng-Hall, 1988, 1991). In the process, members may be either unaware of the expectations of others or of their own critical way of judging others. Elucidation and recognition of this script is paramount, since it typically involves blaming, avoidant and denying mechanisms that hinder adaptive family functioning. Application of the aforementioned problem solving skills is an additional method to resolve conflict more effectively. Improved communication often accompanies this process.

Anger is a common emotion in the setting of grief. Clarifying its source is important, as is acceptance that the loss may be grossly unfair. The desired objective is to be able to deal with such and other frustrations without them leading to destructive hostility. Family members may also need to clarify differences that exist between them. Tolerance is fostered through a process that acknowledges and respects these differences. Some families may have to consider the role of forgiveness and recognize the advantages of ‘coming together’ at such a profoundly challenging time. The feelings of the dying person can powerfully influence members, especially when he or she calls for peaceful cooperation and mutual support. Facilitating the group’s attention to this wish can spur them to relate more tolerantly and compassionately.

(i) Death. Despite the universality and inevitability of death, it is often untimely and unwelcome. Many deal with this by denial and avoidance. The therapist meets the family where they are psychologically situated, adopting their language in facing the death. Commonly, one member will ask about prognosis and so open up discussion of death. Anticipatory grief ineluctably follows as sadness about the pending loss is shared and the worth and contribution of the ill member is reviewed. Reminiscences of this nature can assist the acceptance of loss. The family needs to strike a balance between anticipatory grief and how they live out their remaining time with the ill member. Excessive premature grieving may mar this final phase. On the other hand, reassurance that such grief is normal is comforting.

(ii) Saying goodbye. This process evolves over time; completing of unfinished business, acknowledging the contribution of each person and expressing gratitude are usually involved. A parent may share hopes and wishes for a child. Since affirmations may be poignantly remembered for years to come, the therapist encourages their expression. The family may easily misjudge the amount of time to say goodbye; guidance by the therapist can be distinctly helpful.

(iii) Care provision. Families may sort out many instrumental issues while meeting together. Particular roles are taken up and certain tasks shared. Practical planning can be subject to a problem solving approach; some members may learn more about medical decisions. The need to complete legal matters tends to become evident.

(iv) Suffering. Families are often ill-prepared for this reality as they lack experience of the emotional pain that may be involved. They may struggle with uncertainty and a sense of helplessness. Open discussion about the role of mutual support can help to ease this suffering. The ill member commonly fears being a burden to his children; this may be a source of much concern. Adult children, however, can actively reassure their parents about the privilege of caring, and thus express gratitude for all that was done for them in earlier years.

(v) Intimacy. While some families use the experience of terminal illness as a springboard towards greater intimacy, others get stuck in awkwardness and embarrassment. Frank communication about bodily changes for instance may pre-empt abhor-
rence developing and any associated hindrance of expression of intimacy. Involvement with friends and extended family remains important.

(vi) Cultural and religious practices. Awareness by the therapist of rituals and customary behaviours is important as endorsing their role and value can empower distressed families. The respect of the therapist for such practices conveys a sensitivity about these spiritually relevant aspects of family life.

(vii) Younger children. Discussion regarding the needs of younger children is helpful; clarifying plans for their care and support is reassuring. Honest communication about the illness and its effects helps the child to cope with the experience. Moreover, clarification of the child’s thoughts allay misunderstanding about the cause of the illness and death.

(viii) Historical issues. Any number of past experiences may influence the family, including relationship breakdowns, bereavements, psychiatric disturbance, job problems, disappointment about lifestyle choices and exposure to terminal illness. Families are unique in this context; therein lies the challenge and potential reward in working with them.

(ix) Good death or disappointment. For some families, events will not unfold smoothly and disappointment may follow. Complex factors affect this final experience. In the event of such disappointment, the added challenge is to make sense of the circumstances and help the family to deal with them as adaptively as possible.

(x) Grief. Eventually the pain of loss engulfs the family and its distress peaks. This is the time of greatest risk for those with limited reserves and coping capacities. Some families will need substantial support during this period. Where a therapist has built a strong alliance, she will be well placed to assist. Our goal of reducing psychosocial morbidity in family members is achieved by maximizing adaptive family functioning. The distress associated with separation from the deceased can thus be eased by a supportive family group that better comforts and cares for its members in their grief.

Consolidation and ending therapy

With progress achieved regarding the family’s concerns, the interval between sessions is increased in recognition of this change. The therapist and the family reach a point when a plan to end therapy can be considered. Members are invited to identify any residual concerns or unfinished business that may need attention, either in formal therapy or independently of it using the strategies learned.

Ending therapy conjures up the theme of loss, the therapist becoming a metaphor for the lost family member. Disclosure of feelings about termination can model again an adaptive approach to mourning. The family is also invited to look to its future, reviewing priorities and new needs. The therapist encourages members to continue attending to family functioning in the months ahead, reminding them that old issues are likely to recur and call for further work. Lessons learned in the sessions will need repetition as the family continues to build on changes accomplished. A message of confidence in the family’s ability to maintain benefits not only affirms and boosts morale, but also reinforces their inclination to take responsibility for achieving this.

FAMILIES PRESENTING DIFFICULTIES

We do encounter families so entrenched in their pattern of functioning that they prove resistant to change. The pull towards the status quo is strong. Engaging these families is difficult as members avoid attending sessions. Given that our model is preventive and by invitation, before clinical problems have necessarily emerged, we respect the wishes of those who do not want to participate. We refrain from labeling these families or predicting difficulties for them, preferring to have them accept ‘ownership’ of issues raised in the assessment.

The clinical state of the dying person often poses a difficulty, since such features as weakness, confusion or pain may interfere with concentration and possible involvement. During palliative care, sessions commonly take place in the home so that the patient can more readily participate. In this setting, the therapist discusses relevant boundaries with the family, such as blocking telephone calls or rescheduling visitors to avoid potential interruptions. Duration of sessions may be modified to accommodate the patient’s limitations. Fortunately, many of these hurdles are surmountable and the family grateful to therapists willing to travel to them (thus enhancing the therapeutic alliance).
FAMILY GRIEF THERAPY: A PRELIMINARY MODEL

When some members remain avoidant, therapists need to take heart in the nature of family systems. As mentioned earlier, working with one part promotes curiosity, with change then reverberating through other parts. However, the therapist may have to accept more modest goals or the possibility of not affecting change at all. Indeed, certain families will have deep-seated problems well beyond the reach of what is essentially a brief intervention. Within our classification most help may be deliverable to intermediate families, least to very hostile ones.

EXAMPLES OF FAMILIES TREATED

To illustrate the model and principal themes dealt with, we now present examples of typical families we have worked with.

The family that finds it hard to trust

Paul had a 6-year history of carcinoma of the prostate, which had been treated with radiotherapy, hormones and chemotherapy (see Figure 1). He had developed spinal cord compression 3 months prior to referral. His grief was intense. As his wife Terri worked full-time, his youngest daughter, Cathy, kept him company much of the time. While the family spoke readily about instrumental tasks, they avoided discussion of Paul’s illness and pending death, ostensibly to protect him.

Terri came from a uncommunicative family that avoided acknowledgement of one brother’s homosexuality. Through the years, when Terri felt criticized by her parents, she had responded with silence. Paul’s father had died in Greece shortly before he met Terri. They had subsequently worked in three countries before he began a business in Australia. Through these years, there had been some marital strain over decisions and control, with unexpressed conflict hampering intimacy and fostering an avoidant family style.

While building up this picture during the first three sessions, much grief was expressed. Paul then died. Subsequently, Terri became ambivalent about continuing therapy, but Cathy ‘acted out’ by abusing alcohol until she could share her grief in subsequent sessions. The family pattern became clearer to them, summed up by Terri as, ‘We don’t ask for support, in fact, we don’t easily ask for anything for ourselves. We find it hard to trust.’

This manner of relating was linked to the pattern in Terri’s family of origin; she grieved the lack of intimacy in her relationship with Paul. From this point on, they were well joined to the therapist and gained further support in later sessions as they became more cohesive, intimate and supportive of each other.

The family that listens but fails to hear

An uncommunicative pattern of relating is illustrated by the family of Mary, aged 47, who suffered from carcinoma of the lung (see Figure 2). This had been diagnosed 2 years earlier; Mary became paraplegic from spinal metastases 2 months before assessment. Previously treated with radiotherapy, chemotherapy and laminectomy, she was thought at the time of referral to have a prognosis of less than 3 months. She was being cared for at home by a community-based palliative care service. Paula, the only daughter, had an elevated Beck Depression Inventory score, suggesting clinical depression.
Assessment occurred in the family home. Issues identified by the family were the level of conflict and the poor relationship between father and children. The two sibs, Paula and John, felt unheard and were unhappy. Mary’s husband Bob feared he might ‘lose’ his children following Mary’s death. The family summed up the problems as ‘Bob listening but not hearing’ and Paula and John ‘retreating and no longer speaking up’. Mary hoped for an improvement in this state of affairs before she died.

In drawing the family tree, the children learned that Bob’s mother had always been domineering, critical with high expectations, and lived by the adage that children should be seen and not heard. Bob had treated his own children in the manner he experienced in his own family.

Mary died following the two assessment sessions, but the therapist was well joined with the family and they met for a further six sessions. Bob supported Paula’s grief effectively and generally maintained improved regard for, and communication with, his children. They acted more cohesively, shared thoughts and feelings more readily, and experienced less conflict as a result of a joint resolve to be more understanding of each other. They were able to comfort each other in their grief and Paula was protected from developing a clinical depression. While old patterns of relating still recurred, the family’s awareness of them proved protective. Both family and therapist were pleased with progress.

Fred
coh 3
exp 0
conf 3
FRI 4

Lorna
coh 2
exp 0
conf 2
FRI 4

Agnes Mark Claire James Laura Rebecca Henry
coh 3 coh 1 coh 2 coh 0 coh 3 coh 2 coh 2
exp 2 exp 1 exp 1 exp 0 exp 2 exp 2 exp 1
conf 1 conf 2 conf 3 conf 3 conf 3 conf 2 conf 1
FRI 8 FRI 4 FRI 4 FRI 1 FRI 6 FRI 6 FRI 6

Figure 3. Family hampered by conflict: genogram of a hostile type of family in which Fred was dying from metastatic carcinoma of the lung. While all daughters were married, the sons remained single. Mark and James have not attended therapy. Subscales are from the Family Environment Scale: coh = cohesiveness, exp = expressiveness, conf = conflict, FRI = Family Relationships Index, whose optimal score is 12 (conf score out of 4 is reversed to add to coh and exp to yield FRI).

The family hampered by conflict

Fred, an accountant, had carcinoma of the lung with cerebral metastases (see Figure 3). Although he and Lorna had seven children, their three sons were not able to be engaged in therapy. The three were said to be quite unable to sit together in one room because of persistent conflict between them. Thus, the family lived as subgroups: the female kinship was especially prominent; the father drank heavily and was remote; and the sons were excluded. The therapist saw the conflict between the boys and the gender division in the family as a reflection of unexpressed conflict between the parents. Rather than seeking to resolve conflicts, the offending person was expelled. The eldest son, Mark, had used intravenous drugs and become HIV positive, a predicament kept a secret from his parents.

While separations and adoptions were secrets in Lorna’s family of origin, there was lifelong conflict between Fred and his brothers. The family could not be intimate as it used secrets and divisions to conceal its sense of shame.
Following Fred’s death, the women mourned together whereas the men remained isolated. The husbands were readily blamed, although Lorna acknowledged and regretted cutting Fred off throughout their marriage. The daughters began to recognize their disappointment in their spouses and consequent tendency to see them as responsible for their problematic relationships. A collective concern developed for Mark’s health. The family came to value the sessions for the understanding and sharing they generated, which they felt unable to achieve on their own.

**DISCUSSION**

Previous studies have not offered sturdy guidelines as to the type of family therapy that might be helpful to the grieving family. In the pioneering study of Paul and Grosser (1965), family members were invited to share their thoughts and feelings about their loss and to seek an understanding of the impact of the death on themselves. Since this work, a mere handful of studies have been conducted to test the effects of family therapy on grief. The findings are strikingly inconsistent, especially if we contrast the work of Lieberman (1978) and Rosenthal (1980) on the one hand, with that of Williams and Polak (1979) and Black and Urbanowicz (1985) and Black and Urbanowicz (1987) on the other.

Lieberman (1978) reported greater benefits from a family approach compared to individual therapy, while the work of Rosenthal (1980) suggested that a family model better engaged the bereaved spouse in parental tasks to the advantage of the family.

Two other interventions failed to show positive change. In the crisis intervention model of Williams and Polak (1979) for families who had lost a relative in a motor car accident, a therapist accompanied the coroner’s staff to engage the families within hours of death and later provided counselling. Rather than preventing morbidity, the investigators candidly conceded they might have disrupted ‘natural’ mourning through their premature intervention; indeed the contribution was experienced as intrusive by the families, which in turn may have hampered their inherent capacity to grieve effectively.

Another family intervention study (Black and Urbanowicz, 1985, 1987) was controlled but limited by a high attrition rate. At 2-year follow-up, no positive effects were evident. However, it must be stressed that no selection was made of families at risk. Although the authors accepted this null result, they were still left with the impression that treatment could help; on the other hand, they conceded the need for replication studies.

The above inconsistent results leave us with corresponding uncertainty about the sorts of grieving families requiring professional help and the most appropriate models of treatment.

The models typically adopted hitherto seek to promote open disclosure of feelings revolving around loss. This had been conceptualized by Paul and Grosser as breaking down avoidant patterns erected as a barrier to optimal grieving. A cathartic process is generated that is ultimately healing. However, in this process it is arguable that cohesiveness is enhanced, and this serves to re-establish the social system and interconnectedness of the bereaved, facilitating in turn adjustment to loss. Social support has long been considered influential, and the family unit is probably its most significant source in bereavement.

Family functioning, in our view, has been a neglected aspect of the therapeutic approach to grief work. Our model corrects this.

Should we target specific families?

Increasingly, we strive to anticipate difficulties and intervene preventively rather than permit problems to grow. However, we must take care that chosen treatments are apt and potentially effective. Selection of those needing care is a pivotal facet here. Consensus among therapists and researchers suggests that many families will deal most competently with grief, leading to its resolution and their re-engagement in creative life. Preventive approaches should not, therefore, be applied across the board, but targeted to those in need. The notion of risk selection and application of criteria to identify those at risk of poor outcome come into sharp relief. In earlier studies, selection on this basis was not a feature. Whereas later researchers can agree on criteria to identify individuals at risk of poor outcome (Raphael, 1984), the question has been how to identify families who will do poorly.

In developing our classification of patterns of family functioning during palliative care and bereavement, we have tried to redress this uncer-
tainty by identifying vulnerable families, free of the uncertainty of recruiting families likely to be well-functioning and therefore not in need.

What models of grief therapy could be adopted?

Conventional grief counselling approaches, well described by Worden (1991), tend to be based on Bowlby’s model of undoing bonds of attachment to the deceased. Recovery is achieved with the formation of new bonds and re-engagement in life. Pragmatically, the therapist fosters reminiscing about the lost person on the premise that the associated emotional expression facilitates working through feelings about the loss. However, this model is not universally accepted, it being argued that sufferers of chronic grief get stuck in a continuing process of painful reminiscence, without evidence of relief and change. Kavanagh (1990) has recommended a behavioural method of response. Adopting yet another paradigm, social theorists argue that, irrespective of the emotions for the deceased, reconstituting the social system in the living through new, meaningful relationships is a key dimension of grief resolution, and needs to be at the centre of any therapeutic approach. Moreover, as families are the common social unit, attention to their functioning may be paramount.

Our classification introduces a new conceptual approach to grief work by promoting the move from dysfunctional to more adaptive family functioning. By increasing cohesiveness, opening communication channels and enhancing problem solving to reduce conflict, we can facilitate a supportive environment which fosters evolution of stronger bonds between family members. The approach, which offers potential for a new social system for the family, echoes an approach intuitively followed by traditional, extended families in former years, one eroded by the demands of modern society.

CONCLUSION

Our model of therapy focuses on improving family functioning as a means to reduce psychosocial morbidity in the context of the death of one of its parental members. Increasing cohesiveness, improving communication and fostering conflict resolution are its key aspects. While this scheme is but one of several relevant to the grief context, we sense that the emphasis on family functioning has the distinct potential to contribute to the well-being of families, who in its absence would be vulnerable to a morbid outcome.

Our model is evolving, requiring both elaboration and tests of its efficacy in the form of controlled trials. We are currently conducting such a treatment study, as well as taking every opportunity in related clinical work to refine our approach.

ACKNOWLEDGEMENTS

This study has been funded by The Bethlehem Griffiths Research Foundation and The Australian Rotary Health Research Fund. We thank the staff of Peter MacCallum Cancer Institute, Mid Eastern Palliative Care Service, Caritas Christi and Order of Malta Hospice and Homecare Service, Mercy Hospice Ltd, Caritas Christi Hospice, Bethlem and St. Vincent’s Hospitals, Melbourne for their clinical support and access to patients. We thank our other therapists, Barbara Donnelly, Marilyn Kenny, Carmel Spottiswood, Rose Heard, Kate Cogan, Judith Zuliani, Barbara Kessel, Esther Elbaz, and Penny Sanderson, and we thank Jackie Clarke and Judy Forsyth for their secretarial support.

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FAMILY GRIEF THERAPY: A PRELIMINARY MODEL
