

Family therapy for the bereaved, Kissane & Hooghe

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FAMILY THERAPY FOR THE BEREAVED

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Family therapy for the bereaved, Kissane & Hooghe

Sharing grief generally aids its healing. Sharing emotions within a family brings reflection on the meaning of valued relationships, helping to activate coping and restoration processes through the most natural source of support, the family. Although both individual and group therapy approaches to bereavement care have been the dominant paradigms historically, use of family therapy bridges across generations, makes use of what is often a very accessible source of support and permits the cultivation of relational meaning as a key dimension of adaptation. Given such logic, it is surprising that systemic therapies have been overlooked for so long among models of grief therapy.

Family therapy in bereavement care has obvious applicability following the death of a child, or the death of a parent leaving bereaved children and adolescents. In working with the elderly, family care connects the surviving widow(er) with the support of their children and grandchildren. Indeed, there are few instances where a family is not accessible for support – perhaps the most isolated or alienated individuals cut off from others; the migrant whose family resides in another country; and the single child who has never reproduced and has deceased parents. For the vast majority of cancer and palliative care patients, relatives can be identified to enable therapy to be commenced preventively before the death of the index patient and then continued into bereavement. Or once bereaved, use of the family reinforces the most natural form of support to foster dialogue and harness mutual support as a pathway to healing.

For most families, their natural resilience serves the needs of the mourning process admirably (Kissane & Bloch, 1994; Kissane, Lichtenthal, & Zaider, 2007). Supportive families comfort one another, recognize and respond to needs and encourage healthy adaptation

among their members. For therapists then, the challenges arise with families in need of specialized help, or families struggling to go on after the loss because of injured relationships, competing ways of coping or lack of mutual support, which potentially handicaps healthy mourning. The development of therapeutic models that aim to reinforce the natural support system for the bereaved, and/or optimize relationships, enhance the functioning of the family and use these very processes to facilitate the sharing of grief, can direct the family and its members down a restorative pathway (Kissane, et al., 2006).

In this chapter, we first explore an approach to engage families in therapy starting during palliative care. We describe its techniques and strategies, offer guidance about the challenges that arise and review the empirical evidence for the efficacy of this approach. Secondly, we explore an approach that relies on the natural support resources of the bereaved to engage families in therapy after the death. In this way, we highlight the fundamental value that a systemic perspective brings. Moreover, we seek to deepen appreciation for relational meaning through the active sharing of vulnerability, the fostering of tolerance and respect, the nurturance of generosity and mutual care provision; in short, we focus on the family grieving together as an efficient and cost effective path to a creative outcome, despite loss and change.

ENGAGING FAMILIES IN THERAPY: FAMILIES AT RISK IN A PALLIATIVE CARE SETTING

In the palliative care setting, before a patient with cancer dies, family members can be invited to complete a Family Relationships Index (FRI) (Moos & Moos, 1981), a 12-item true-false scale, which informs about family cohesiveness, expressiveness of thoughts and feelings and conflict resolution, and has good sensitivity to identify families at risk of psychosocial morbidity during bereavement (Edwards & Lavery, 2005; Kissane, et al., 2003). Those families

considered at risk are invited to attend a family meeting, where their issues and concerns about caring for the dying family member can be appraised and continuing family therapy contracted with the members (Kissane, 2000). Therapy readily continues into bereavement once a therapeutic alliance is established.

Predicting how much therapy any family may need

Repeated studies have confirmed a typology of families based on their relational functioning as defined by the FRI (Kissane et al., 1996; Kissane et al, 2003). Two types of families are well functioning: the first is termed *supportive*, and these families are highly cohesive, communicate readily, comfort and support one another, are free of conflict and their resilience protects their membership from psychiatric disorders and complicated grief. The second well-functioning type is termed *conflict resolving*, because their open communication and high cohesion protect their members from difficulties, despite prominent differences of opinion. They are also free of psychiatric disorder during bereavement. Neither *supportive* nor *conflict resolving* families are in need of preventive family therapy.

Three types of families have reduced cohesiveness and communication, and are troubled by conflict. *Intermediate* families have mild reductions in communication and teamwork, carry some members in need of psychological help and are readily amenable to being engaged in therapy. Generally 6- 8 sessions of therapy over as many months will help intermediate families share their grief and protect members from adverse psychiatric outcomes (Kissane et al., 2006).

Of the more dysfunctional family types, *sullen* families have poor communication and cohesion, but muted anger; they carry the highest rates of depression (anger turned in) and

accept help, generally needing 8-12 sessions of therapy over 12-18 months to prevent complicated grief (Kissane et al., 2007). In contrast, *hostile* families are fractured by conflict, use distance as their means of survival, and may not be willing to come together for therapy. If they can be engaged, therapists may be wise to set more modest goals, but can expect 12-16 sessions of therapy over 18 months to be needed to prevent adverse outcomes for those families engaged in treatment (Kissane et al., 2006). An acceptable compromise is to work with an accessible part of such a family and help those open to this assistance.

The empirical typology delineated above helps conceptually to recognize families where attachment processes are more disturbed and accurately predicts rates of psychiatric disorder (Kissane & Bloch, 2002). However, we avoid classifying families by these names clinically, lest harm be done by pejorative labeling. It is sufficient to say to families with *intermediate*, *sullen* or *hostile* levels of functioning that experience teaches us the value of meeting with the family-as-a-whole to help patients and their care givers manage the illness and care provision.

Conducting therapy in the home

Arranging therapy in the home of the primary caregiver is common in the hospice setting. This practice increases the ability of the ill patient to take part in early sessions despite their frailty and thus become known to the therapist before death intervenes (Kissane & Bloch, 2002). Families are very appreciative of this and the therapist is better able to bring the deceased back figuratively into the therapy, given their personal knowledge of the person. The wishes and hopes of the lost relative can be powerfully used to motivate the family to sustain efforts at mutual support. When high conflict is recognized in families, therapists are wise to

conduct the initial assessment sessions on neutral territory rather than the home, until confidence develops about the safety of therapy in the home.

Once families become bereaved and return to their communities, more barriers emerge to engage the family than is seen within a hospice program, because the relatives disperse to their various homes across cities or states and geographic impediments arise. Telephone linkage to a family meeting is manageable if one sibling lives distantly, but becomes impractical if several are scattered.

The more dysfunctional or fractured the family is, the more difficult it becomes for a willing therapist to engage members, who fear rekindled conflict, may doubt the capacity of the therapist to facilitate anything beneficial and prefer to assume the solution of distance as their coping response to their differences of opinion and relational style (Zaider & Kissane, 2009). There may be great wisdom in the solution already adopted by such a family. Miracles cannot be worked and without the opportunity for healing engendered by having a relative dying, the motivation is often absent to reconsider this *modus operandi*.

Sometimes one family member serves as the symptom bearer and rationale for a reluctant group of relatives to come together. Here the therapist plays actively on the needs of a psychiatrically ill relative, whether the symptom cluster is a clinical depression, or another variation of reduced coping. The invitation to assist a clinician in helping someone who is acknowledged to be ill serves the systemic function of avoiding any blame on the family-as-a-whole. This constellation helps then to convene and engage the family in therapy. Nevertheless, therapists need to actively reach out to all family members and invite them to attend, lest the hesitancy to get involved prevails strongly for the majority. A wise therapist works with

whoever is available and later invites outliers to attend, telling them something of the dynamics discovered and emphasizing the role they could take up to the benefit of the family or ill family member. A letter from the therapist summarizing what has been understood of the family's strengths and challenges can serve as a vital inducement to draw together reluctant participants. Many a time, early separations, divorces, or conflicts have left unfinished business, which can itself be a motivation for the family to reconvene in the hope of resolution of hurts from long before.

Susan and Bill were often asked by their father to make excuses on his behalf as teenagers when they recognized his infidelity, an alliance that cast them into unwelcome awkwardness with their mother. His advanced illness and an associated family meeting provided them with an unanticipated opportunity to revisit ambivalent feelings and gain an apology from their dying parent before it was too late. The active sharing of these feelings facilitates grief resolution, rather than leaving anger repressed and more likely to persist chronically as prolonged grief disorder (see Chapter XX).

Goals of therapy

Therapists work to facilitate a constructive process, wherein families grapple with both enabling versus restrictive choices that flow from a deepened understanding of who they are and where they might go to accomplish the following goals:

1. To recognize that illness, loss and change bring normal human emotions of grief (their mourning) alongside a transition point of opportunity for review, reconnection and reconfiguration, flowing from choices about relational life (their coping);

2. To make explicit the family's relational pattern of valued and meaningful connections (their strengths) that invariably sit in balance with differences in interests, temperament and goodness of fit, the latter creating tension and disagreement in family life (their vulnerabilities);
3. To foster acceptance of their heritage, who they are and can choose to become, while clarifying the potential pathways of mutual respect and care, recognition of similarity and difference (their acceptance of reality), and adoption of celebration and commitment, tolerance and forgiveness, closeness or distance that flow as choices in continuing relational life (their constructive choice of outcome); and
4. To support them through a period of revisiting, reconnecting, reconciling and reconfiguring as they mourn and adapt to their choice of future family life.

This therapeutic process is consistent with theoretical constructs of dual process (oscillation between loss-orientation and restoration-orientation) (Stroebe, Schut, & Finkenauer, 2001), attachment theory (Ainsworth & Eichberg, 1991; Bowlby, 1977), social-cognitive reframing of assumptive worlds (Janoff-Bulman, 1989; Parkes, 1972; see also Chapter XX) and processes of group adaptation (Whitaker & Lieberman, 1964). These therapeutic objectives benefit from being modest in their ambition to effect change, respectful of personal autonomy and choice, and wise about the systemic forces that operate at any given time, struggling between maintenance of what is familiar and growth through novelty and creativity.

Techniques used by therapists

The goals of therapy are accomplished through the establishment of a trusting alliance, the creation of a safe environment for exploration and growth in understanding, a curiosity

fostered by skillful questions and eventually an integrated understanding by the family through the process of balanced summaries. Traditional principles of family therapy are represented by circularity, neutrality and hypothesizing (Cecchin, 1987). Each of these merits brief definition.

Although the therapist's natural warmth, interest, enthusiasm and compassionate care must shine through, avoidance of being drawn into any alliance with individual or subgroup is essential to serve the good of the family-as-a-whole: *neutrality*. This stance is made possible through the asking of naturally inquisitive questions, but also through posing these sequentially to different family members to gain varied perspectives that make explicit the dynamic forces operational within the system: *circularity*. Such inquiry is driven by wisdom and insight, which permits the therapist to recognize the potential competing views and to respect the family's ability to make constructive choices when its relational processes are made explicit: *hypothesizing*.

The questioning technique needs to be facilitative as its circular process of moving around the room unfolds. Much use is thus made of the diverse views of family members, helpfully placed in tension, one with another, to emphasize the richness and variety of family life, and especially the blending of backgrounds that marriage creates. Construction of a genogram across three generations usefully highlights relational patterns that repeat themselves from generation to generation, together with patterns of coping with loss and death, especially when these can be contrasted with adaptive and maladaptive features (Kissane, Bloch, McKenzie, McDowall, & Nitzan, 1998). Such exposition of transgenerational patterns maintains respect and avoids blame through the family's recognition of inherited dispositions.

Tomm's model of investigative and facilitative questions casts the therapist's role as catalytic, yet non-directive, through the framing of words that invite reflection (reflexive questions) or consideration of choice (strategic questions) (Dumont & Kissane, 2009; Tomm, 1988). Many opinions, intriguing stories and much confounding material inevitably emerges, necessitating the vital skill of constructing integrative summaries that clarify the group's mutual understanding and fosters its coherent recognition for all involved. The active naming of patterns, relational dynamics, similarities and differences, tensions and balances, and coping response styles is grist for the mill. Importantly, affirming what robustness and resilience is present counters any awkwardness for the family in naming their vulnerabilities. Linking the latter to transgenerational patterns increases acceptance and tolerance, while also inviting choice over whether the family repeats or varies any behavioral response to key events that disrupt ordinary life.

Structuring all of the above within a framework of focused therapy helps the family make sense of any plan to accomplish achievable goals of family therapy. This negotiation needs to be both explicit and achieve consensus to ensure cooperation and commitment to the potential work that can be pursued. Movement must occur from the perspective of attending as a care-provider to assist (or simply a bystander who watches) the sick person, to ownership of family membership in a team that wants to realign its shared direction to collectively and collaboratively work towards the mutual benefit of all. Unless members can recite their goals--to communicate feelings more openly, to cooperate more generously, to respect differences-of-opinion more thoughtfully--the holding frame of therapy has not been established to create shared confidence about the objectives being pursued together. Making a commitment to

Family therapy for the bereaved, Kissane & Hooghe

attend four or six sessions over as many months necessitates working through ambivalence about these collective pursuits. Considerable therapist skill underpins any agreement reached by the family to continue to work together in a mutually supportive manner to achieve overtly shared goals.

Themes met within oncology and palliative care

In the cancer setting, talk about death and dying proves an obstacle for many families wanting to avoid distress and to protect patients from becoming demoralized about their plight (Zaider & Kissane, 2010). For patients accepting their reality, however, its acknowledgement begins the conversation about farewell, with its accompanying expressions of gratitude and future hopes and dreams for the survivors. For those unable to acknowledge the finitude of their life, avoidant coping blocks any sharing of anticipatory grief; therapy is often sought by some relatives wanting more open communication about end-of-life preparation. Families in these predicaments often want to know from a potential therapist whether he or she will collude with their protective stance before agreeing to meet as a group.

Once death has occurred, the story of illness, its diagnosis and treatment, mired with myriad complications and challenges along the way, becomes the essential narrative for the family to share and integrate into its history. Conflict over the medical approach, caregiving roles, and the distribution of tasks and responsiveness of those involved are common themes that replicate relational dynamics from years before. Therapists strive to move beyond the concrete facts to better recognition of patterns of relating and responding; relatives often prefer to battle on about the minuscule details. Nevertheless, most therapy makes progress when deeper understanding emerges about the interactional styles and related choices.

Unresolved conflicts, affairs, or family secrets present barriers to open communication across the generations, whether such perceived wrongs involved a criminal, sexual, homosexual, or mentally ill dimension and occurred in the context of abuses, thefts, bankruptcies, gambling debts, drunken violence or contagious disease. Issues of shame, hatred, vengeance, violation or complicity impact on the related emotions that co-exist with these complex issues. Sometimes the truth must emerge for the healing of complicated grief, but the family needs time to establish trust and confidence that a safe environment can be maintained to work through the associated affects.

Cultural and ethnic traditions and religious beliefs form another constellation of issues that may influence the course of the therapy and themes needing to be discussed (see Chapters XX and XX). Blended families that create a mixture of backgrounds bring considerable diversity to the work, sometimes with reasons for migration, divorce or separation never having been fully explained before. Sensitivity, patience and wisdom are crucial therapeutic attributes.

Evidence for efficacy of family therapy commenced preventively during palliative care

A randomized controlled trial has demonstrated the ability of family therapy commenced during palliative care and continued into bereavement to protect families from complicated grief and depressive disorders (Kissane et al., 2006). Smaller effect sizes were evident for more dysfunctional families (Kissane et al., 2007), leading to dose intensity studies now being conducted with support from the National Cancer Institute in the USA. We anticipate that families with only mild or *intermediate* disturbance in their functioning will gain from relatively brief periods of intervention, whereas *sullen* and *hostile* types will need more prolonged support over 18 months.

Illustrations of challenging cancer families

Mild family dysfunction can become quickly responsive to improved communication when protective barriers have been well intentioned, yet not conducive to adaptive outcome.

"I remember – my mother died of cancer...it was so difficult for everybody and... somehow I want to make it a little better for us...we would talk to each other about my mother, but she was the one dying and nobody talked to her about what they were experiencing."

.....

"There are things that I feel we don't talk about and I understand why...but I feel like it's something I'd like to do if it's appropriate...[pause]. We don't talk about me dying and I'd like to."

.....

More severe family dysfunction can mask and perpetuate clinical depression unless the relational issues are defined and understood as necessary therapeutic targets.

Daughter 1: How are we all going to deal with Brenda's depression?

Brenda: I wish my old therapist was still practicing.

Therapist: Who in the family could Brenda pick up the phone to and say, "It's been a month since mommy died and I'm really missing her? Who would Brenda be likely to turn to first?"

Daughter 1: I think she's most comfortable confiding in our brother, Don.

A therapist used to the individual setting will typically feel the urge to respond empathically to distress voiced by a family member. Yet more powerful support can come from relatives around the circle. Questions to others about the tears seen in one party can facilitate the development of compassion and mutual support, with the capacity for it to be sustained beyond the therapy. Key differences in therapeutic style are paramount for effective family work.

Joe had spent ten years in an orphanage as a child, leaving him with a vulnerability to abandonment that had been assuaged by his marriage to Sheila. Her death cast Joe back into a lonely state, despairing, "It feels like a flood and I have to swim through it, and I cry and feel ashamed of this. My uselessness! A timeless life! I am withered up. I have nothing. I think of suicide." The daughter, Maureen, was also bereft as the remaining woman of the household. Both sons, Peter and Chris, had created independent lives away from the family home. Therapy gave them insight into the need to support Joe and Maureen, visiting regularly and engaging with them until the pain of grief began to ease. The therapy contained their distress, and although Joe and Maureen declined referral for individual treatment, the family sessions guided them supportively across 18 months until they both re-engaged in life.

Dependence on alcohol, profound aloneness, suicidal thoughts to achieve reunion, preoccupation with physical symptoms and personal health, traumatic memories of the death, guilt over unresolved wrongs, blame and criticism of others, spiritual doubt and despair...many forms of distress are seen in the bereaved (Kissane & Bloch, 2002). A family approach can

helpfully deepen the support and rally the family's assistance when the pain of loss seems devastating.

In very different, non-cancer, settings of bereavement or traumatic grief consequent upon family violence, the collective experience of members constitutes an important reason to grieve together. When suicide or homicide has happened within the family, revisiting the violence in the safety of a contained therapeutic environment can be restorative to members unable to otherwise express their rage at the deceased.

ENGAGING BEREAVED FAMILIES IN THERAPY: RELIANCE AND REINFORCEMENT OF NATURAL SUPPORT RESOURCES

When confronted with the loss of a loved one, most people rely on their own strengths and that of the social network they live in to face the challenges of grief (Bonanno, Wortman, & Nesse, 2004; Boss, 2006; Shapiro, 2008). However, some search for more support or professional guidance. As therapists, we can only offer a temporary connection. Therefore, we emphasize the importance of connecting the bereaved with their own natural support network, where many people receive the ongoing human connection needed for resiliency (Boss, 2006). Inspired by Boss's concept of the 'psychological family' (Boss, 2006) and Landau's construct of 'network therapy' (Landau, 2007), we broaden the conception of 'family' within this model to persons who are perceived as supportive, concerned and willing to help.

In the following, we describe a case to illustrate how we can help the bereaved by optimizing reliance on and reinforcement of their natural support resources. From a collaborative approach to psychotherapy (Anderson & Gehart, 2007), we aim to make space for stories to be shared. At the same time, we want to attend to the possible tensions and

Family therapy for the bereaved, Kissane & Hooghe

hesitations involved in this exchange (Hooghe, 2009; Hooghe, Neimeyer, & Rober, in press; Rober, 2002), and the possible value of silence, for the individual, as well as for the system (Baddeley & Singer, 2010).

Inviting other family members: a dialogue between different voices

When someone seeks individual therapy, the therapist can immediately encourage their attendance with other family members. Thus,

Mieke, age 42, sought psychotherapy following the loss of her 16-year old son, Pieter, who died ten months ago. During the first few months after his death, she had “coped quite well”, but now she felt “stuck in her grief” and wanted someone to talk to. As her appointment was arranged, she was asked if she could bring others from her family who could help the therapist to better understand her “stuckness.” She seemed surprised by this request, stating that she had assumed she would come alone, but immediately added that she could ask her husband to come along. Her husband, Koen, aged 47 years, was recently diagnosed with a brain tumor and was currently receiving chemotherapy.

Inviting other family members to the therapy sessions generates multiple perspectives and brings varied meanings into the conversation. In the dialogue, new meanings are interactively produced between all those who are present in the therapy room (Bakhtin, 1981; Seikkula, 2002; Seikkula & Arnkil, 2006). Additionally, already existing or sometimes new support resources are enforced.

Talking about talking

As therapists, we don't want unilaterally to promote the expression of grief, but rather to create a space and opportunity to explore with family members the possibility of sharing their grief experiences with others.

For the first session, Mieke and Koen come together as a couple. From the very beginning, it is obvious that Koen, the father, attended because his wife had invited him and not because he personally wanted to talk. While Mieke began by telling the story of their son's death, Koen looked around and appeared somewhat anxious. As his wife described the haunting images of Pieter hanging with a rope around his neck in his bedroom, the therapist wondered how it was for Koen to listen to this. Koen replied firmly, "I came because Mieke said I needed to come along. I will surely not come along each time." Then he added, "I don't have a lot to say, I'll listen. There is nothing we can do about this. Pieter won't come back by talking about it." Immediately Mieke pointed to their very different ways of coping with their loss. Quite often, she wondered if Koen cared about having lost his son. This comment caused Koen to be even more upset. The therapist expressed curiosity about Koen's way of dealing with the death of his son, highlighting that the difference between bereaved mothers and fathers is a common challenge in bereaved couples. Bereaved fathers might avoid therapy in which they would be invited to talk or listen. The therapist also added that she had learnt from many bereaved fathers that sharing their grief is not always experienced as helpful. She wondered, "How is this for you?" Koen explained, now less defensively, that he usually "takes things as they come" and does not feel the need to talk about the loss. "This is how I am, it passed, leave it quiet, it will go away." Remarkably, he added, "But perhaps

for Mieke, this is different,” and Mieke replied “Well, Pieter was that way too, like his father.”

As marital and family therapists, we want to foster tolerance for the different meanings attributed to the loss, for different views and ways of understanding what happened, together with recognition of the varied coping styles of partners and family members who are grieving (see Chapter XX). In this case, the therapist’s acknowledgement of the challenge posed by each parent having different response styles created some space for a less argumentative atmosphere. It then became possible to learn more about their unique ways of coping. Not only the tendency to share grief with others, as in the case of Mieke, but also the ambivalence to talk and desire to “*leave it alone*,” as in the case of Koen, are considered to be coping styles with equal value. Through a collaborative approach, we explore how they each experience such talking about the pain of their loss. This ‘talking about talking’ (Fredman, 1997; Hooghe, 2009) is somewhat different from the dominant approach in individual psychotherapy, and more specifically in grief therapy, where the emphasis is usually put on the importance of sharing grief in order to create a stronger bond, a sense of togetherness and relational intimacy (Cook & Oltjenbruns, 1998; Gottlieb, Lang, & Amsel, 1996; Hagemeister & Rosenblatt, 1997; Sedney, Baker, & Gross, 1994). Some authors in the bereavement literature have advocated for a balanced view about the degree to which talking or not talking is beneficial for individual couples or families (Couper, et al., 2006; Hooghe, et al., in press; Rosenblatt, 2000a, 2000b). For the father, Koen, his reluctance or hesitation not only concerned the *talking* about the loss in the context of this therapy, but also about *listening* to his wife’s stories. Listening brings a

distressing confrontation with the loss, which for some can be experienced as painful, useless, or too disruptive (Hooghe, 2009).

Engaging possible resources of the bereaved

In the initial phase of therapy, but also during the whole therapy process, we can explore possible support resources with our clients.

Towards the end of the first session, the therapist and the couple talked about Koen's choice not to come along subsequently. The therapist asked Mieke if she would invite somebody else whom she thought would prove supportive of her grief. Mieke commented that their 19-year old daughter was also unlikely to come. Lovingly, she mentioned that their daughter is like her father and brother, mainly wanting to push forward and not dwell on what had happened. Encouraged by the therapist, she decided that she would ask her daughter nevertheless. Furthermore, Mieke thought that her own sister, Greet, who lives in same village, would be most willing to accompany her.

Sometimes there is a thin line between being respectful of patient's choices (e.g. choosing not to attend, or preferring to come alone), and our own therapeutic objective to strengthen possible connections in the natural network (Hooghe, 2009). This can be a real dilemma.

Empowering the bereaved to choose who attends, rather than assuming that it should be the whole family, or particular family members (e.g. both bereaved parents as partners, the children of the bereaved widow), honors the bereaved as experts on their own life situation and their resourcefulness. Often, the bereaved do not want to be a burden to others by inviting them to therapy. If so, the therapist can help to explore any ambivalence to invite these relatives. Although we want to respect their choices, we also want to keep in mind the close

relational network in which the bereaved is embedded in daily life. We can do this by frequently inquiring about them, for example by asking about the impact of the grief process and the therapy on them. Sometimes we don't know whether a particular relative refuses to come, or whether he or she was never invited. Encouraging the bereaved to bring their relatives at least once can give us a better understanding of their relational network and possible support resources. Often, an initially reluctant relative decides to take up a genuinely supportive role for the good of the family.

Sharing grief creates new meaning

During collaborative narration, or joint storytelling, families engage in sense-making (Koenig Kellas & Trees, 2006; see also Chapter XX). Or, as Nadeau (Nadeau, 2008), puts it, "Out of their conversations, threads of meaning start to emerge and, over time, these threads become woven into a tapestry of family meanings." Hence, shared meaning-making within the family is both encouraged and actively facilitated.

For the next seven sessions, Mieke attended with her sister, Greet. First, they talked about Koen's absence. Mieke accepted his decision, noting that her husband was content to have met the therapist and to appreciate where she would be going for future sessions. For Mieke, it was important that he came initially. She reflected, "I always thought he didn't care much, but now I understand that he is just too afraid to talk about it. And, you know, he came because he loves me." Now, she also felt thankful towards her sister Greet, who attended willingly, and with whom Mieke thought she might be able to share a lot of her grief.

During subsequent sessions, they talked a lot about Pieter, who he was, how he had been confronted with identity struggles, how Mieke found his dead body, tried to resuscitate him, and how she had been trying to go on with daily life since his death. In the presence of her supportive sister, an atmosphere emerged to comfortably share these stories, some that had never been told before. The therapist was privileged to hear their stories as they, at times, expressed surprise about their somewhat different experiences. They brought up a lot of memories together; they laughed sometimes, cried often and comforted each other frequently.

While most of the time Mieke's experiences remain central, both Greet's similar and diverse perspectives about life enrich the conversation, bring new meanings, new stories, and perhaps most importantly, creates an experience of shared grief.

Reinforcing human connection in the natural context

As therapists working with grief and bereavement, we can feel powerless in the face of devastating and irreversible loss. However, from a family or network perspective, we aim to strengthen the competencies and resiliency of the survivors through their family, thus reinforcing human connection in its most natural context. As was the case for Mieke, faced with inconceivable losses, coming to the sessions with her sister clearly deepened the connection between them.

As family therapy progressed, Koen's brain tumor worsened and his chemotherapy did not hold his illness at bay. Sadly, he began to decline quickly, became frailer and dependent, needing much help from his family. Mieke stopped working and took care of him in a loving way. She knew he would die soon. The therapy sessions served as a

sporadic but helpful respite, while her husband was cared for at home by a nurse.

Gradually, stories about Pieter's death transitioned to Mieke's grief over Koen's cancer, stories of the care he needed, and his pending death. With her sister Greet, she shared her loneliness, her fears, and even began to plan for Koen's funeral. Often, the therapist inquired about Mieke's daughter, Veerle, who would soon lose her father, only one year after she had lost her brother. Although Mieke had frequently invited her daughter to attend therapy, Veerle preferred the support of her boyfriend, and reassured her mother that she would come if she felt the need.

The therapist discovered that these two sisters developed their own ritual while driving to therapy. While the actual journey took only 20 minutes, they allowed a full hour. Laughingly, they admitted that they have their "own secret spot, somewhere down the road" to talk together on the way. After each session, they regularly treated themselves to an ice cream as a reward for their hard and emotional work. In this way, they connected for more than three hours during each evening they came to therapy.

One week after the seventh session, Mieke called the therapist to say that Koen had died. The last days of his life had been "horribly painful, but also very connected and loving." At the funeral, Mieke expressed appreciation not only for the therapy, but especially for the wonderful connection with her sister, who had been beside her, often silently, in these last days of Koen's life.

This illustration highlights poignantly how these sisters not only could be a rich support for each other in the sessions but also, and even more importantly, how their relationship served them deeply in the real world. The therapist felt quite powerless to lighten the pain of

these cruel losses, but the model of therapy fostered enhanced connections with relatives that could be relied on. Family resources can be creatively harnessed to good effect through such deeper connection, mutual support and the therapist's confidence in the robustness that emerges despite great adversity and grief.

INTEGRATIVE CONCLUDING THOUGHTS

When illness, death and grief enter our lives, we are not only deeply moved emotionally, but these experiences also inevitably challenge our beliefs, our world view, who we are and whom we relate to. We need to reconstruct our individual sense of identity, as well as our family's sense of identity as a whole. We feel intense pain, perhaps a sense of devastation or suffering, alongside other potential feelings of love and gratitude. Each loss impacts upon all of our relationships, while these, in turn, can be an important resource of support. From a family therapy perspective, the value of the relational network in which the bereaved is embedded is paramount. As professionals working with palliative care and bereavement services, we can create the opportunity to join with the families of those dying, thereby utilizing the natural continuity that exists between palliative care and subsequent bereavement. For families 'at risk' of increased challenges in their grieving processes, we can initiate a shared family process, in which meanings can be exchanged and created anew through the family's shared dialogue.

Of course, some of the bereaved only reach us long after death has occurred, presenting for therapy at different times in the grieving process. Although the majority might initially contact professionals expecting individual assistance, this individual therapy approach for the bereaved potentially neglects the natural resources available through their family, friends and

local community. Here we have presented a systemic model of bereavement care, one that can be applied preventively to those deemed at some risk, or one applied acutely for those with emerging or established complications of grief. Recognition of the family as an ally to the therapist has the potential to shorten the overall requirement for bereavement care and lessen its intensity through having family members join as a supportive network for those most deeply affected by the loss.

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