

THE UNIVERSITY OF MANITOBA
LIBRARY

AUTHOR PICHORA, Raymund J.

TITLE A SOCIAL WORK APPROACH TO DYING AND BEREAVEMENT

.....

.....

THESIS M.S.W., 1984

I, the undersigned, agree to refrain from producing, or reproducing,
the above-named work, or any part thereof, in any material form, without
the written consent of the author:

..... *S. Burke*

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

THE UNIVERSITY OF MANITOBA

A SOCIAL WORK APPROACH TO DYING AND BEREAVEMENT

BY

RAYMUND J. PICHORA

A PRACTICUM REPORT SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF SOCIAL WORK

SCHOOL OF SOCIAL WORK

WINNIPEG, MANITOBA

OCTOBER 1984

FACULTY OF GRADUATE STUDIES

Report on Master's Requirement in Place of the Thesis

This is to report that the student whose name appears below has completed the requirements as outlined.

Name of Student Ray Pichora

Student Number 0731083

Major Department Social Work

Requirement: (Please indicate result)

Comprehensive Examination (69.701)

Practicum (69.703)

M. Eng. Project & Report (69.704)
(3 Credit Hours)

M. Eng. Project & Report (69.705)
(6 Credit Hours)

X (PASSED)

Ruth Leckles

Dyce Sanderson

John A. Kuyper

Aug 31, 1984
Date

(Committee of Examiners and/or
Department Head, where applicable)

A SOCIAL WORK APPROACH TO DYING AND BEREAVEMENT

BY

RAYMUND J. PICHORA

A thesis submitted to the Faculty of Graduate Studies of
the University of Manitoba in partial fulfillment of the requirements
of the degree of

MASTER OF SOCIAL WORK

© 1984

Permission has been granted to the LIBRARY OF THE UNIVERSITY OF MANITOBA to lend or sell copies of this thesis, to the NATIONAL LIBRARY OF CANADA to microfilm this thesis and to lend or sell copies of the film, and UNIVERSITY MICROFILMS to publish an abstract of this thesis.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

ACKNOWLEDGEMENTS

I would like to express my appreciation to Joe Kuypers, Ruth Rachlis and Joyce Sandison for their time, thoughts and incisive perception. Without their support, this practicum would have been a task of insurmountable proportions. My thanks are expressed to the staff of St. Boniface General Hospital and particularly to the staff of 2 ECU. Their ongoing assistance and direction helped transform the conception of the practicum into reality.

I am especially grateful to Anne for her patience, time and perseverance.

TABLE OF CONTENTS

	Page
Acknowledgements	i
Table of Contents	ii
Chapter	
1. Introduction	1
2. Reactions to Death and Dying as Experienced by Chronically Ill Adults and Their Families	3
I Introduction	3
II The Intrapsychic View of Dying and Bereavement	3
A The Dying Process Debate	3
B An Overview of Dying--Death Trajectories	5
C The Analysis of Dying	6
III Individual Reactions to Bereavement	15
IV The Interactional-Systems Approach to Dying and Bereavement	29
3. The Existential-Developmental Life Cycle View of Dying and Bereavement	41
I Introduction	41
II Coalescing Life Cycle Theory and Existentialism	42
4. The Crisis Aspect of Dying and Bereavement	51
I Introduction	51
II Crisis Theory	52
III How the Crisis Occurs and Evolves	57
5. Interventions	64
6. Practicum Overview	77
I Clinical Summary	77

	Page
II Practice Issues Raised in the Practicum	81
III Themes and Issues Raised by the Case Reports . .	88
 Appendix--Case Reports	
I Mrs. A.	93
II Mr. B.	99
III Mr. C.	102
IV Mrs. D.	106
V Mr. E.	113
VI Mr. F.	117
VII Mrs. G.	123
VIII Mr. H.	131
Bibliography	137

CHAPTER ONE

Introduction

The issues raised in the abundant literature of death, dying, bereavement, mourning and grief suggest a number of themes. These issues are central and prerequisite to an understanding of the fundamental processes of life and death as seen on a continuum of existence to nonexistence.

The issues raised in the literature seen on a superficial level, have developed from the discussion of practical everyday questions such as should the dying patient and his family be informed of the diagnosis and prognosis, to what is the nature of the psychological processes of death, dying and bereavement. The eclectic and broad range of the literature suggests themes which, taken together as parts of a greater whole, facilitate the development of theory, hypothesis, intervention, strategy and evaluation. However as with the development of treatment strategies with many social problems, the development of theory in working with the dying and bereaved has outdistanced the testing and development of interventive strategy.

As Sobel comments:

Any psychotherapy or counselling method should be based on science, regardless of our attachment to particular analytic, existential, or behavioural theories. Theories help us understand human behaviour and organize diverse information, while the science of clinical psychotherapy dictates the most promising and empirically supported approach to change. As most of us recognize, this has always not been the case in psychotherapy. Theories have gone untested. Clinical prescriptions

have been blindly applied by tradition or a priori assumptions. Integration of paradigms often lags far behind relevant information on treatment efficacy (Garfield and Bergin, 1978). Clinical thanatology is not an exception to these trends. In fact, the nature of its topic contributes to an even stronger detachment from empirical perspectives. (Sobel, 1981, p. 5)

While the gap between theory and a clear articulation of intervention strategy may seem unscientific and crude, it is nonetheless a normal phenomena in the evolution of clinical practice. What begins as practice wisdom ultimately can develop into a proven, effective treatment approach. The discrepancy between theory and practice can in part be ascribed to a lack of clear understanding of the nature of man and social problems. As Paul Tillich has stated:

No therapeutic theory can be developed without an implicit or explicit image of man but we must go beyond this step. No doctrine of man is possible without a general understanding of the general processes of life, their trends and their ambiguities. And finally, no understanding of life processes is possible without a doctrine of being and a structure of being universally. In this way the practice of clinical thanatology can be seen as initially attempting to reach some level of intellectual conviction about the nature of man, human problems and the fundamental issues of life. (Ruitenbeek (ed.), 1962, p. 8)

To attempt to deal in a thematic, issue oriented way with the literature on dying and bereavement, the subject will be dealt with under the headings of: (1) the debate concerning the nature of the psychological processes involved in dying and bereavement; (2) the existential-developmental-life cycle theory view of dying and bereavement; (3) dying and bereavement seen as a crisis; intervention; and literature overview.

CHAPTER TWO

Reactions To Death and Dying As Experienced By Chronically Ill Adults And Their Families

I Introduction

The literature concerning dying and bereavement overwhelmingly deals with the subject from an intrapsychic perspective. The re-deeming feature of the predominance of this intrapsychic viewpoint, is that many writers attempt to approach the question interactionally in terms of social role performance and expectations. In other words, many writers attempt to understand what is occurring within the individual experiencing death or bereavement so as to reach an understanding of what the terminal patient's family may be experiencing. Therefore while the literature in general will be presented; particular emphasis will be placed on developing a systemic understanding of dying and bereavement. Moreover, as we shall see, dying and bereavement are parts of the same process which mutually effect each other resulting in a systemic circular process of action and reaction.

II The Intrapsychic View Of Dying and Bereavement

A. The Dying Process Debate

Kubler-Ross has been criticized by Shneidman (1973, pp. 6-7) and Kimmel (1980, p. 517) for seeing the process of death and dying as a unidirectional, linear progression from denial to anger and so forth. Instead Shneidman (1973) views the process as marked by the ebb and flow of emotions with slippage constantly and unpredictability

occurring in progression or regression with some phases omitted initially or entirely. In this way as the terminally ill individual and his family recall problems solved and unsolved, deeds done and left undone, and experience feelings of guilt, fear, loneliness, remorse, satisfaction or joy, the process of ebb and flow inexorably occurs between denial at one extreme and acceptance at the other. However, on a close reading of Kubler-Ross's initial treatise On Death and Dying (1969), it seems that Kubler-Ross did not intend the stages of death and dying to be viewed as Shneidman and others suggest.

In discussing the operation of the stages, Kubler-Ross comments that: "These means (sic) will last for different periods of time and will replace each other or exist at times side by side. The one thing that usually persists through all these stages is hope." Then in her later book Questions and Answers on Death and Dying (1974, p. 25) Kubler-Ross makes this clear when she states:

I hope I am making it clear that patients do not necessarily follow a classical pattern from the stage of denial to the stage of anger, to bargaining, to depression, and acceptance. Most of my patients have exhibited two or three stages simultaneously and these do not always occur in the same order.

Similarly, Weisman (1972) suggests that there are phases of dying instead of stages. Weisman describes an ongoing, intermingling of emotional responses which occur throughout the dying process. Weisman describes these phases as the acute crisis phase, the chronic living-dying phase and the terminal phase. Weisman suggests that it is during the acute phase that clients may be most in need of help in terms of crisis intervention to avoid a chaotic disintegration of the client's life during the remainder of the living-dying process.

B. An Overview of Dying-Death Trajectories

Pattison (1976, p. 82) suggests that when the diagnosis is given, or the outcome of the disease is anticipated, a crisis of the knowledge of death is induced. Former plans and activities must be suddenly rearranged or discarded entirely. Incongruency emerges between the actual set of life circumstances and the former potential life trajectory. The lifespan seems to be abruptly, perceptibly shortened. Instinctual response systems are invoked and death expectations are evoked. The form of the expectations are a function of the nature of the disease and its virulence. Death expectations anticipate the content and process of the living-dying interval between the crisis knowledge of death and the point of death. The style of living with impending and possible death, Pattison describes as "death trajectories." Pattison suggests that death trajectories can be best understood in terms of Weisman's phases of dying.

The concept of death trajectories was first suggested by Glaser and Straus (1966). The trajectories include: certain death at a known time, certain death at an unknown time, uncertain death but a known time and uncertain death and an unknown time. The first trajectory (certain death at a known time) is a rapid one in which transition to death is perceptibly very short as is the interval for confronting outstanding issues. The second trajectory (certain death at an unknown time) is commonly associated with chronic fatal illness such as is experienced by patients with terminal illnesses. The third trajectory (uncertain death, but a known time) is commonly associated with radical surgery which will either result in a continuance of life as before, or will yield to the trajectory of certain death

at an unknown time. The fourth trajectory (uncertain death, and an unknown time) is defined as applying to multiple sclerosis and genetic diseases that result in a life ambiguity for the patient and his family.

Certain trajectories are inherently easier to deal with than others. Pattison (1976, p. 84) suggests the certain death, unknown time trajectory is difficult to cope with as the living-dying interval may stretch over a number of years. In this trajectory prolonged emotional stress can have serious consequences for the terminal patient and his family as they live with persistent and constant awareness of the reality of impending death. Pattison suggests a criteria of certainty be applied to the trajectories to determine which may lend themselves to adaptation more than others. Accordingly, Pattison concludes that the trajectory of uncertain death, and unknown time would be the most difficult with which to cope. The trajectory presents an irresolvable situation as the possible outcome of death and when death may occur are both unknowns. High levels of anxiety and maladaptive defenses result, symbolically representing this uncertainty.

C. The Analysis of Dying

Kubler-Ross (1969) has pointed out that preparation for death involves five sets of reactions including: denial, anger, bargaining, depression, acceptance and hope.

As has been mentioned in the debate concerning the dying process, Kubler-Ross has described the process and sparked controversy. What has been presented is a comprehensive view of dying but not necessarily a blueprint of what each death experience will entail. The discussion begins with denial and ends with acceptance and hope. Inferences

are frequently drawn that the process moves from threatened pathogenesis to healthy death. This fallacy concerning the process may in part result from negative connotations associated with denial, anger and depression. Denial in fact is not pathogenic nor is acceptance necessarily desirable. While describing how denial functions as a buffer protecting the patient and his family from the initial shock of awareness of the terminal illness, Kubler-Ross states:

Denial, at least partial denial, is used by almost all patients, not only during the first stages of illness or following confrontation, but also later on from time to time. Who was it who said, "We cannot look at the sun all the time, we cannot face death all the time?" These patients can consider the possibility of their own death for a while but then have to put this consideration away in order to pursue life. (Kubler-Ross, p. 39)

Pattison (1975, p. 85) suggests that there are four levels of denial. He defines existential denial to be "our fundamental approach to mortality and the place of death in one's life." Pattison suggests that in varying degrees, using existential denial is a necessary mechanism for existence. The validity of Pattison's comment can be debated given the fact that finding and being motivated to find meaning in life is directly related to a subjective and personal awareness of death as a possibility in everyday life. This shall be discussed in more depth later. Pattison's second level of denial is psychological denial in which hospital staff, physicians, terminal patients and their family attempt to repress that which is known and conduct their lives as usual. The third level of denial Pattison sees as non-accepting denial in which there is pervasive denial of death. Denial becomes such an overwhelmingly predominant defense that it becomes a major problem. The fourth level of denial is defined as non-attention denial

as attention is for the moment engaged elsewhere and impending death recedes from, in gestalt terms, the figure to the ground of our consciousness.

Weisman (1972, p. 63) suggests that there are four successive psychological steps which constitute the basis of denial. He defines the steps to be: acceptance of the perception that one is terminally ill; repudiation of the implicit finality of terminal illness; substitution of the repudiated terminality with a less threatening belief in ultimate cure; and the reorientation of the patient towards social existence exclusive of the reality of death and dying. Weisman's characterization again points out that denial of death provides a hiatus or buffer allowing for a gradual adjustment of social and emotional functioning.

Ernest Becker (1973) also has suggested that the denial of death has become an ideology of existence permitting the operation of society as we know it. Becker begins with the assumption that life is basically nasty, brutish and short in which there is no order, predictability or sense. To survive in this chaos, we repress our sense of vulnerability, weakness and frailty by ignoring our awareness of mortality in constructing the myth which we conceive of as our civilized sense of reality. There is no objective reality which is absolute and can be rationally understood. Reality is our construction of life which permits us to live as if we will never die. The ultimate reality of life in death is too frightening to be confronted directly. Therefore we have constructed a heroic myth which exalts progress and achievement and offers the deceiving, yet comfortable reassurance that life triumphs over death always.

In terms described by Becker, effective grief work by the dying and bereaved is then universally and culturally impeded. The mass media extolls the virtues and proliferates the values of youth, pleasure and the pursuit of unbridled happiness. The reality of aging, sickness, pain and dying is regarded as distasteful or obscene and is thereby ignored. This process of denial culminates in an illusion of harmony and peace in life which discourages confronting and dealing with the sorrow of personal loss and the psychological wound of bereavement. Our social denial of death thereby discourages appropriate resolution of grief and what has been described as appropriate death. Weisman (1972, p. 15) defines appropriate death as:

One in which there is reduction of conflict, compatibility of the ego ideal, continuity of significant relationships, and consummation of prevailing wishes. In short an appropriate death is one which a person might choose for himself had he an option. It is not merely conclusive; it is consummatory.

Beilin (1981) has described the social functions of death denial. He suggests that death denial serves a positive social function by normalizing the situation and thereby preserving relationships threatened by awareness of terminal illness. Death denial is also invoked by the collaborative process of the sick role which involves the patient, relatives, friends and hospital personnel. By means of the sick role, the terminal patient is able to engage doctors and nurses in a reciprocal helping relationship thereby insuring continuation of medical treatment and care. The trappings and ritual of medical practice and healing create an illusion that recovery is not only possible but a reasonable expectation.

Similarly the sick role has the effect of evoking expressions

of caring and affection from family. Sometimes when there has been a prolonged separation between elderly parent and adult children, the illness becomes a convenient, face-saving way of initiating contact. The sick role also provides an acceptable excuse or alibi for exemption from social responsibilities which can be conducive for continuing family functioning and altering role distribution. Therefore Beilin sees denial as effectively functioning to keep the terminal patient socially alive. Then, inevitably as the perception of physical deterioration assaults the belief in recovery; rising expectations flounder in the glare of barren disappointment. Beilin sees denial at one end of a spectrum with death - affirmation at the other end. Thus, Beilin seems to discount death - acceptance in favor of assuming that one can merely recognize the fact of ultimate death.

Faced with all their fears, the terminal patient will usually, it not always, at some point, experience a sense of anger which Davidson (1975, p. 19) views as a protest reaction to death as an intrusion into life. This anger is typically displaced randomly on to people or institutions in the environment. Doctors, nurses, social workers, housekeeping and pastoral staff may be alternately or uniformly regarded as incompetent, cruel and thoughtless. The patient's anger may frequently seem to be irrational and staff and family may feel tempted to respond personally if the anger is perceived to be directed at them. This reaction is frequently the result of fear or sorrow and loss of family and friends as future plans and accustomed activities are interrupted, and perhaps permanently suspended. Resentments may also be expressed by the terminal patient which are symbolic of past family conflicts and cause a reawakening of old

vulnerabilities. (Kubler-Ross, 1979, p. 79)

Symbolically, in anger the patient's behaviour cries out "'Why me? Why couldn't it have been somebody else?'" (Schulz, 1978, p. 70). Considered from the perspective of a discovered conspiracy of denial or failing system of denial, hostility sometimes expressed by patients and family is an understandable protest against the dying process.

Bargaining may become part of the emotional trajectory (Schulz, 1978) of the dying in a desperate attempt to play for time which in some ways can be seen as a new dimension of denial and anger. Bargaining in this way is an attempt to postpone the inevitable by attempting to strike a bargain with God and sometimes hospital staff for a little more time, frequently with a self-imposed deadline so that living may go on before the business of dying continues. The elements of denial implicit in this bargaining may be indicative of a quiet protest against the inevitable or a sense of guilt concerning the non-performance of social roles in the family, community or work place. Kubler-Ross (1969, p. 82) also ascribes a religious connotation to bargaining; "If God has decided to take us from this earth and he did not respond to my angry pleas he may be more favourable if I ask nicely."

Depression is experienced by the terminal patient when an overwhelming sense of loss pervades and life itself becomes perceived as a threat. (Davidson, 1975, p. 19) As Pehm (Hersen and Bellack, 1973, p. 236) has stated:

Depression has been considered to include the following classes of behaviour in the verbal cognitive area: (1) sad affect, (2) reports of decelerated behaviour and lack of motivation to perform a variety of activity, (3) hypochondriacal complaints, and (4) distortions of experience in the form of guilt, negative self-evaluation, pessimism about the world and the future etc.. In the overt-motor area, depression includes: (1) behaviour of depressive typography such as sad demeanor, head hanging, and crying, and (2) deceleration of activity level, which includes a variety of measures of motoric and speech activity.

Simply stated Pehm is perhaps referring to: a marked inability to enjoy anything, a loss of appetite or overeating, insomnia or sleeping too much, overreacting or not reacting at all, difficulty in concentrating as well as remembering and making decisions, becoming upset by trivial things, feelings of worthlessness and social withdrawal. Sometimes terminal patients experiencing depression seriously consider ending their own lives and suicidal acts have an increasing appeal. (Hinton, 1977, p. 86) The key factor in the seriousness of the depression according to Hinton (1977, p. 87) is the degree of pain and physical discomfort which if uncontrolled increases the misery of the patient. The fears of the dying again play a prominent role at this time as the defense of denial begins to break down. The patient's sense of belonging to this world is weakened and bitter disillusionment may take hold. (Hinton, 1978, pp. 88-89). Kubler-Ross (1969, p. 86) differentiates between reactive depression and preparatory depression experienced by the terminally ill. Reactive depression is a focussing on past losses while preparatory depression results from a contemplation of impending losses. Kubler-Ross points out that this preparatory depression is functional in that it helps the terminally ill prepare for the loss of all love objects. Preparatory depression

is thereby necessary for an acceptance of death in terms of separation from the love objects to occur.

Patients may reach an acceptance of their death. Kubler-Ross (1969, pp. 112-113) defines acceptance as a completion of mourning for the impending loss of so many meaningful people and places, and a growing degree of quiet expectation. Kubler-Ross stresses that acceptance should not be confused with resignation which she sees as a hopeless giving up possibly accompanied by declarations of "what's the use" or "I can't fight any longer." This is an indication of the beginning of the end of the struggle but are not indications in themselves of acceptance. Kubler-Ross also describes acceptance as not a happy stage either, but rather conceives of acceptance as a void of feelings in which communication becomes more non-verbal than verbal as a patient begins to decathect. Kubler-Ross (1979, p. 13) defines decathexis as "the opposite of cathexis, which is attachment, conscious or unconscious of emotional feeling and significance to an idea or an object, most commonly a person." Kubler-Ross suggests that acceptance can be best described as an experience of primary narcissism similar to the egocentrism and concrete thinking of infancy. Kubler-Ross suggests Bettelheim's description of infancy as being most apt: "Indeed it was an age when nothing was asked of us and all that we wanted was given. Psychoanalysis views earliest infancy as a time of passivity when we experienced the self as being all." (Kubler-Ross, 1969, p. 120). For acceptance of death to be attained by the patient, the opportunity to express their anger and mourn in preparatory grief must have been available and utilized by the patient. This does not imply

that acceptance is an absolute therapeutic goal to which patients must be motivated by family or professional intervention. As Kubler-Ross (1979, pp. 36-37) points out:

The ideal would be if both the dying patient and the patient's family could reach the stage of acceptance before death occurs. In that case there is little if any grief work to do though there is, naturally, grief in either case. It is not our goal, however, to push people from one stage to another. If the patient requires more time in a given stage or if he has no intention of really facing his finiteness, or if he prefers to remain in the stage of denial, we do him a better service to allow him to stay in the stage of denial. If a patient has been angry all his life long or was a revolutionary or a fighter, it is much more likely that he will remain in the stage until the moment he dies. If someone has been a depressed personality and is filled with self pity and remains this way until the end of his life, it is very unlikely that he will be cheerful and that he will accept his own dying with a smile on his face and a sense of equanimity.

Conflict may arise between a patient and his family if while the patient accepts his death, the family does not. This can lead to demand for life prolonging treatments and heroic measures when these would only subject the patient, who would otherwise die, to the indignity of having his wishes and needs ignored.

Unlike other writers on the subject of dying and bereavement, Kubler-Ross stresses the importance of hope. Hope is the common denominator of all reactions to dying and bereavement and may offer the patient a sense of meaning in his suffering. Hope may also offer even in the acceptance of death, a temporary but necessary interval of denial. Temporary remissions of various forms of cancer may allow patient and family some hope and ease passage through the living/dying process.

III Individual Reactions to Bereavement

Individual reactions to the experience of grief have been studied by Lindemann (1944), Bowlby (1961), Pollock (1961), Parkes (1965), Speigel (1977), Hardt (1978) and Pattison (1976). Each of these authors and many others, deal with the question of how the bereaved adapt to terminal illness and the death of their loved one and maintain equilibrium in the presence of confluent and emerging social, economic and emotional disruption and disturbance.

Lindemann (1944) describes the symptomatology of normal grief as consisting of sensations of somatic distress, intense preoccupation with the image of the deceased, strong preoccupation with feelings of guilt, disconcerting loss of warmth, irritability and sometimes hostile reactions in relationships with other people, loss of patterns of conduct in terms of difficulty performing customary tasks and activities of daily living and disrupted patterns of social interaction. Lindemann suggests that during the course of normal grief reactions, grief work is undertaken which he defines as "emancipation from the bondage to the deceased, readjustment to the environment from which the deceased is missing and the formation of new relationships" (Lindemann, 1944, p. 143). A major obstacle to successful grief work is the natural instinct of self preservation and a tendency to avoid awkward or threatening situations. Also, culturally prescribed repression of emotional pain and its associated manifestations reinforce the barrier to grief work. The fear of breaking down results in intense expenditure of emotional energy to maintain a facade of detachment or indifference thereby cutting off the supply of emotional energy necessary for grief work. Lindemann regards the demonstration by the bereaved of the

deceased's characteristic traits, behaviour or symptoms of his illness, as bordering on the pathological. Lindemann suggests this exaggerated behaviour or preoccupation with the image of the deceased constitutes operationalization of displacement and identification defence mechanisms. Morbid grief reactions are seen by Lindemann to be distortions of normal grief and normal grief work. Morbid grief reactions are divided by Lindemann into two broad categories: delay of reaction and distorted reaction. Lindemann describes nine types of distorted reaction including: overactivity without a sense of loss, acquisition of symptoms belonging to the last illness of the deceased, acquiring a recognized medical disease, alteration in relationship to friends and relatives, serious hostility against specific persons, repression of hostility to the extent that interaction becomes wooden and formal with affect and conduct similar to that seen in schizophrenia, lasting loss of patterns of social interaction and activity detrimental or destructive to social and economic existence, and agitated depression with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation and an apparent need for self-punishment. In terms of intervention, Lindemann suggests that the essential task of the therapist is to share the client's grief work particularly as attempts are made "at extricating himself from the bondage to the deceased and at finding new patterns of rewarding interaction." (Lindemann, 1944, p. 147). Lindemann also assumes that under reaction to bereavement can be just as significant as overreaction. Lindemann stresses that the pain of bereavement must be accepted by the bereaved. To facilitate this task, Lindemann recommends that the bereaved must review their relationship with the deceased, develop emotional self-awareness and

work through fears of insanity, emotional volatility and seeming irrational hostility. Lindemann also touches upon the concept of anticipatory grief and suggests that it may form an important safeguard against a sudden death notice but may form serious impediment and obstacle to relationships should death for some reason not occur as expected. Anticipatory grief may also enhance adjustment to bereavement by families following the death of a chronically ill family member by activating problem-solving mechanisms and capacities that may reduce the amount of unfinished business following the death.

Bowlby, in "Processes of Mourning" (1961), specifically attempts to understand mourning by utilizing the hypothesis he developed elsewhere regarding the nature of the child's tie to its mother. Bowlby's hypothesis suggests that the emotional tie between the bereaved and the dead loved one is mediated by instinctual response systems which constitute man's inherited behaviour repertoire. This hypothesis stresses the roles played by the loved object, the nature of efforts to retain the loved object and the need for social attention derived from the loved object which persists after the death of the object. Bowlby suggests definitions of mourning and grief. He defines mourning to be "the psychological processes that are set in train by the loss of a loved object and that commonly lead to the relinquishing of the object." (Bowlby, 1961, p. 318) Instinctually, the immediate response to mourning consists of craving, angry efforts to recover the object, and other immediate attempts to meet this need by appeals for help. The psychological processes then shift as depression and apathy occur resulting in some disorganization of behaviour which begins to resolve itself when a reintegration on a higher or lower, stable level of

functioning begins to develop. Bowlby suggests that the criteria for determining whether mourning is pathological or healthy, is to be drawn from hindsight inferences in terms of whether or not the individual is able to relate to new objects and find intrinsic satisfaction and purpose in them. Bowlby defines grief as: "the sequence of subjective states that follow loss and accompany mourning." (Bowlby, 1961, p. 318) The subjective states that Bowlby identifies as constituents of grief are anxiety, anger and despair as the loss seems to be perceived as irretrievable.

Bowlby suggests that mourning consists of three phases: protest, despair and detachment. In this schema the individual's attachment to his loved object continues and persists after the death of the object. As the object is absent and can no longer be possessed, instinctual response systems are activated in which the bereaved individual experiences disappointment, separation anxiety and grief given the knowledge that the object has ceased to be. However these instinctual response systems cannot easily be terminated and there are strenuous and angry efforts on the part of the bereaved individual to recover the lost object. Bowlby suggests that anger demonstrated during mourning seems to have two primary objectives. Frequently anger is directed against those who the individual can blame for the loss or hold responsible for the loss. Secondly, anger is also directed at those who are perceived to be impediments to the recovery of the lost object. This anger is intimately related to the source of sorrow in the process itself as the bereaved strive to ameliorate and cure the pain engendered by the persistent craving and insatiable yearning for the lost object. Sometimes the anger may be directed primarily

against the lost object itself as it is held responsible for its absence. This anger can be repressed and/or displaced towards objects in the environment and sometimes to the self as well. Bowlby seems to ignore the role of guilt as a potential source of anger. Attempts to recover the lost object are sometimes seen in searching behaviours that signify a hope for a magical return of the lost object and a maintenance and preservation of the status quo. In this way the painful adjustment to a new way of life without the deceased or the achievement of a new equilibrium would become unnecessary. Bowlby suggests that pathological mourning results when the bereaved become fixated in the protest phase of mourning. In this fixation, the bereaved without being necessarily aware of what they are doing, persistently continue attempts to recover the object despite the evidence of reality testing that this is impossible. As reference to reality is sometimes then proven to be fruitless, the image of the lost object for the bereaved can sometimes become distorted by wish fulfilling fantasy which makes it even more difficult for the bereaved to relinquish the lost object. They come to see the world as a barren place in which the nature, tone and tenor of the relationship with the lost object can never be replaced or reexperienced with any other object.

Therefore, inherent in the process of mourning, whether it be healthy or pathological, is some regression and disorganization of the personality accompanied by pain and despair as the loss is felt. In the third phase of mourning detachment a resolution and reorganization of the personality takes place as the image of the lost object becomes supplanted by a new object or objects as hope emerges and triumphs. In short, Bowlby suggests the central feature of mourning,

which is the key to understanding it as healthy process and also in terms of its psychopathology, is how and if the insatiable and persistent yearning and craving for the lost object is resolved. For Bowlby, the healthy resolution of mourning, carries with it the implicit statement that "my loved object is not gone, for now I carry it within myself and can never lose it". (Bowlby, 1961, p. 325)

Pollock (1961) takes a very narrow intrapsychic view of the mourning process as an adaptation of the internal psychological milieu to a changed external milieu to reestablish a steady state of equilibrium and constancy. This view sees the individual as a system unto himself solely and not as a subsystem of larger system whose collective functioning is more significant for the individual than the individual's functioning on his own. Pollock however does raise a number of important considerations which are relevant to understanding the mourning process in terms of family dynamics. Pollock suggests that the nature of the relationship between the bereaved and the deceased before the death occurs is an important factor in determining the course of the resulting mourning process. Pollock as well takes the view that while the mourning process seems to follow a sequential pattern, a definite ebb and flow in terms of progression then regression in the process as a whole is the rule rather than the exception. Pollock also suggests that the process consists of shock, grief, pain, reaction to separation and the beginning of internal object decathexis as the loss is recognized. In these terms, Pollock sees the process as developing from an acute to a chronic stage as adaptational mechanisms attempt to integrate the experience of loss with reality. The integration occurs as reality-testing induces a natural selection process leading to

a different way of life. Pollock describes Freud's view of mourning work as the consolidation of adaptational activities which are present in the chronic stage of the process. However, Pollock fails to recognize that mourning is not strictly a one way adaptational process of the internal milieu to external stimuli. The adaptation of the external to the internal is the subject of the interactional systems approach section which follows. Undeniably, powerful external stimuli affect the adaptation of the internal milieu to dying and bereavement. Our pervasive cultural denial of death impinges on everyday life, including adaptation of dying and bereavement. The exaltation of youth-oriented values dictates devaluation of illness, aging and the aged as symbolic reminders of mortality and death. Thus dying and bereavement are relegated to an untouchable, psychological ghetto. (Becker, 1973) As this system of death denial ritual becomes built into social interaction; a formidable adaptational task is created for the internal milieu to maintain equilibrium in the face of death.

Pollock comments that the formation of new relationships is more an indicator of the degree of resolution of; rather than part of the mourning process itself. Pollock's characterization of the significance of new relationships, however, questions his intrapsychic approach to mourning. If the process was purely intrapsychic, surely the appropriate indicator of resolution of the process would be an intrapsychic measure rather than one based on the social milieu of the bereaved. It is undoubtedly true that the formation of new relationships is a reliable indicator of the resolution of the mourning process. It seems rather obvious that if this is a reliable measure, then the mourning process must be more than a purely intrapsychic one.

This leads to the thesis of this paper that the mourning process is regulated not only by the individual's coping mechanisms and capacity, but also by the nature and structure of family dynamics, and social systems of which the bereaved are members.

Parkes (1965) in his studies of bereavement and mental illness, takes exception to Lindemann's use of the term "morbid grief reactions" and suggests instead that the terms complication of grief or atypical grief should be more appropriately used. Parkes argues that the term morbid grief reaction is both internally superfluous and misleading as grief is by definition a reaction and also implicitly refers to dysfunction of a greater or lesser degree and of unspecified duration.

Parkes hypothesized that the typical reaction to bereavement varies according to the closeness of the relationship with the deceased. He suggested that when the deceased is of "first order kin to the survivor," the initial reaction can be delayed or a period of numbness occurs in which the bereaved may behave as if nothing had happened. Parkes says that this can last from a few hours up to an estimate of two weeks. Subsequently attacks of yearning and spontaneous distress occur. This he describes as waves which seem to be aggravated by reminders of the dead family member. Between the waves of distress the bereaved display depression, apathy and a sense of hopelessness. Parkes describes specific symptoms to be insomnia, anorexia, restlessness, irritability and hostile outbursts directed against others and sometimes to the self, together with a focussing on memories of the deceased. The deceased may be felt to still be present, the bereaved tend to think of the deceased as if he were extant and idealization of the deceased's memory occurs. Parkes suggests the intensity of these

symptoms begins to decline after one to six weeks and have largely faded by six months. Occasionally there may be brief periods of yearning and depression for several years precipitated by death anniversaries or other reminders of the deceased and his loss. Parkes identifies eight atypical grief symptoms to be prolonged grief, intensified grief, persistent self-blame, persisting difficulty accepting loss, delay of reaction for more than two weeks, occurrence of the symptoms of the deceased in the bereaved, panic attacks and other symptoms including urticaria, headaches, histrionic outbursts, obsessions and compulsions, compulsive laughter, phobia of cancer, headaches and hypochondriacal depression.

Parkes also describes stress-specific grief responses to be: typical grief, chronic grief, inhibited grief and delayed grief. Parkes enumerates non-specific responses to be: psychosomatic reactions, psychoneurotic reactions, affective disorders not resembling grief, and other conditions such as schizophrenia, sexual deviation and relapse in chronic alcoholics.

Spiegel (1977) regards the mourning process as consisting of a succession of shock, control, regression and adaptation. While it can be said that Spiegel deals primarily with mourning as a result of sudden death, his observations can also be extrapolated to the reactions to death and dying by the families of chronically ill adults. Shock immediately sets in with either the observation of the death or the receipt of the news of the death. There may be disbelief, as if the death is somehow unreal and has not actually occurred. A review of the history of the illness may take place and a question regarding the unavoidability of the death may be raised. Frequently the bereaved

exaggerate the importance of certain omissions that they have made in their duty to the deceased and reproach themselves for this neglect or lack of attention. Sometimes the state of shock can be so great and overpowering that a physical collapse results with an apparent temporary total withdrawal into the self, cessation of normal behaviour and interaction, disruption in the activities of daily living and transitory memory loss. Sometimes this breakdown does not occur in as noticeable a way but invariably there is a shedding of tears, the bereaved appear to be numb, difficult to relate to, sometimes unaware of their environment, and seemingly unable to think clearly and express themselves thus. Occasionally the bereaved may respond to the death of their loved one with a stoic response in which the reality of the death is apparently accepted and the emotions are not allowed to display themselves. This type of response can meet with considerable social approval and expressions of admiration by the friends and family of the bereaved. This type of reaction however can be extremely misleading as it may be indicative of delayed or inhibited grief.

Spiegel describes the control stage as characterized by internal controls exercised by the bereaved upon themselves and by social controls exercised upon the bereaved by family or friends. During this stage, the bereaved seem and feel very passive and experience difficulties in decision-making. The role of "transition technicians" namely medical and ancillary medical personnel as well as undertaker and funeral director, allow the bereaved time to become self-controlled as the responsibility for the social activities necessary to arrange a funeral and burial are removed directly from their hands. The rush of activity occurring around the bereaved, produces a dreamy feeling of

distance between the bereaved and his world which Spiegel describes as derealization and depersonalization. Spiegel suggests that the bereaved feel empty. The deceased and the world as well seem to be very unreal as if orientation to person, place and time is temporarily distorted or out of joint. How the bereaved perceive themselves may be similarly affected as the bereaved feel a dominant sense of distance from themselves and experience difficulty identifying their behaviour and actions as actually being their own. A characteristic of the emotional energy that the bereaved direct towards self-control is their irritability and occasional unreasonable suspicion and hostility towards friends and relatives in an obvious indication of vulnerability and emotional fragility. Similarly to Bowlby, Spiegel suggests that unexplained irritability and hostility is an attempt to deny acknowledgment of the reality of the death and the subsequent change required in relationship and lifestyle. Therefore the involvement of others can be regarded as an unwanted intrusion and interference with a continuing relationship to the deceased.

Spiegel describes the stage of regression as a collapsing of psychic organization previously founded on interaction with the deceased. To begin a process of reorganizing, and adapting, "the mourner refers back to the forms of coping less differentiated and more independent from the environment, that is more narcissistic." (Spiegel, 1977, p. 70) Spiegel summarizes the regressive stage to be:

Personalization, preoccupation with the deceased, simplification of complex facts and value systems, misjudging the value of the deceased, guilt and anxiety feelings as well as self-devaluation. All of this is connected with the experience of heightened emotionality which can lead to either excessively affectionate behaviour or aggressive behaviour marked by vulnerability, irritability and mistrust. (Spiegel, 1977, p. 77)

The stage of regression serves a dual purpose. It is both a mechanism to cope with the experience of death while at the same time it conserves energy so that a psychic, family and social reorganization can occur.

During the stage of adaptation, regressive forms of behaviour are given up and abandoned as new adaptive forms of behaviour are found, and adopted; adaptation occurs and an adept sense returns to behaviour.

In his description of the systems of pathological coping with grief, Spiegel suggests that the bereaved may become "stuck" (Spiegel, 1977, p. 61) in the shock, control or regression stages. Ironically, the bereaved may also display severe inability to begin the process despite the fact that the emotional tie with the deceased may have been a close one. The bereaved may become overly dependent on the support of others or inexplicably irritated with others if fixation results during the controlled stage. Spiegel also suggests that the bereaved may become fixated in regression if the mechanisms of regression continue past more than six weeks.

Specifically, Spiegel identifies a number of situations surrounding death which can prove to be particularly pathogenic. Of particular interest here in the study of the dying of chronically ill adults and the bereavement of their families, Spiegel postulates that:

"I can say that the more unexpected the death, the more acute and disturbing the grief; the more prolonged the illness, the more one can accomplish the most painful part of mourning in anticipation of the loss." (Spiegel, 1977, p. 84)

Spiegel suggests that anticipatory grief may pose particular difficulties for the dying. He points out that: "the dying person, who

himself struggles with separation anxiety and the fear of death, must also bear the grief of his family and their gradual turning away from him." (Spiegel, 1977, p. 86) This illustrates very clearly the point made here that dying and bereavement are systemic processes influenced and shaped by family dynamics, the life cycle stage the family has reached, and the individual coping skills of the family members. Physical pain may be heightened if the dying perceive themselves as abandoned by their families. However, the dying process also offers the bereaved family an optional opportunity to improved life after death. Thus the dual character of dying and bereavement as a time of risk and opportunity is clear.

Spiegel discusses particular situations which are most pathogenic for grief. Those most applicable to the study of reactions to dying and bereavement as experienced by chronically ill adults and their families, include: suicidal death; an ambivalent love-hate relationship between the deceased and the bereaved; a socially isolated survivor whose relationship had been very dependent on the terminally ill patient; whether the death was one of a series of crises which were not adequately worked through because of their rapid succession; if death coincides with a normal developmental life crisis; whether the loss is such that a new relationship or relationships cannot fill the void left in the survivor's life by the death; whether there is a shared susceptibility to disease; if there has been a history of emotional instability and disturbance; and lastly, the sometimes extended length of the dying process as in a terminal illness. (Spiegel, 1977, pp. 93-94)

Spiegel describes grief work to consist of: "release of grief,

restructuring, acceptance of reality, the decision for life, expressing socially unacceptable emotions and experiences, evaluating the loss, incorporation of the dead, new life orientation." (Spiegel, 1977, pp. 94-95). In Spiegel's consideration of the bereavement process, he seems to neglect any analysis of the importance of the role of depression in the process.

Hardt (1978) has utilized the Thurston Equal - Appearing Interval Attitude scale to measure attitudes towards death. On the basis of his research, Hardt hypothesizes that the mourning process consists of five phases or stages consisting of shock, denial, false acceptance, pseudo-reorganization, depression and reorganization/acceptance. Hardt's description of the mourning phases seems to bear a close relationship to Spiegel's delineation of the process of mourning.

Pattison (1976) suggests that to understand the experience of grief, we must understand what ego coping mechanisms the bereaved employ. Pattison rejects the term defense mechanisms in favor of coping mechanisms as ego defenses constitute a normal part of psychological development which are acquired for psychological security to develop in the face of the demands of the world. Pattison proposes that to adequately assess the coping of the bereaved, we must understand the developmental life cycle of the bereaved and how ego coping mechanisms develop throughout the life cycle. Pattison has developed a hierarchy of ego coping mechanisms which coincide with the developmental life cycle. The hierarchy consists of four levels of ego coping mechanisms including: primitive, immature, neurotic, and mature ego coping mechanisms. Under primitive-coping mechanisms, Pattison includes delusions, perceptual hallucination, depersonalization,

reality distortion and denial. Under immature coping mechanisms, Pattison includes: projection, denial through fantasy, hypochondriasis, passive-aggressiveness and acting-out behaviour. Under neurotic-coping mechanisms, Pattison includes intellectualization, displacement, reaction formation and emotional dissociation. Under mature-coping mechanisms, Pattison has included altruism, humour, suppression, anticipatory thought and sublimation. He categorizes the use of this hierarchy of typical ego coping mechanisms on the basis of occasional, moderate and considerable use. In acute crisis, Pattison notes that the initial reaction is likely to consist of a transient response of maladaptive coping mechanisms to be followed by a gradual progression towards the more mature coping mechanisms. What is most important however is that Pattison points out that how we deal with dying will not differ markedly from how we deal with life itself. In this comment, Pattison affirms the value stance that death is very much a part of life.

IV The Interactional - Systems Approach to Dying and Bereavement

Kubler-Ross (1969, p. 169) has commented that the family of a terminal patient experiences the same stages of preparation for death as does the patient. Moreover Kubler-Ross (1969, p. 161) suggests that if a terminal patient can successfully undertake his own grief work then he will show his family an example from which they can learn and in this way help them to meet death. This viewpoint is the one that shall be stressed in the intervention section of this paper which is to follow and will be demonstrated in the case reports. This perspective stated in another way implies that the terminal patient can positively or negatively influence how his survivors cope with his

death and dying. As the bereaved family attempt to adapt to their environment without their deceased loved one; the ease or difficulty of the adaptation will be affected by the nature of the death trajectory. Pathological progression of survivors' grief is also similarly influenced. Conversely, how the family react to the dying process will affect how the terminal patient copes with his impending death. The basic point is that in considering the reactions of the terminal patient and/or his family and friends, they cannot be dealt with in isolation from one another. Any change in one part of the client system will inevitably affect the entire system.

Orcutt has described the psycho-familial social system approach as viewing:

This orientation views the dying patient/family - in - environment as a systemic configuration of different hierarchical orders and levels of system differentiation. The family system, as conceptualized, is an aggregate of mutually interacting parts or members and maintains a dynamic balance in functioning. The family relational system is more than the sum of its individual member interactions, and changes in any member relationships reverberate throughout the system. (Orcutt, 1977, pp. 23-24)

Approaching dying and bereavement from a systems point of view has the advantage of normalizing the process and removing the stigma of pathology. Dealing with the issues in this way, aids in counteracting social injunctions denying the reality of suffering inherent in the process. Thus, the open expression of emotion, feelings and information can be perceived as normal and an acceptable part of living with dying and bereavement. A difficulty with this family systems perspective in dying and bereavement is that a relative void exists in the literature on the subject. Perhaps it is an indication of the

infancy of thanatology in its theoretical and clinical aspects, which accounts for the dominance of the intrapsychic perspective. Nevertheless this writer is in agreement with Kubler-Ross in her statement, which she does not elaborate upon, that the terminal patient and their family experience the same process.

Kimmel also suggests that the bereaved experience a process that is comparable to that of the dying person and thereby family and patient can assist each other with their experience. (Kimmel, 1974) This leads to a systems perspective on dying and bereavement between patient and family. As pointed out by Pincus, patient and family are both subjects in their own right while also being each other's object; and the object of each other's attachment. Thereby the coping and adaptive ability of patient and family are geared and related to each other. (Pincus, 1976) In this way how a terminal patient dies will influence how the survivors cope with the death and dying. The converse is therefore also true that how surviving family adapt to the dying process may affect how the terminal patient copes with his impending death. The basis point is that the terminal patient and/or his family and friends cannot be dealt with in isolation from one another. Any change in one part of the client system will inevitably affect the entire system.

Separation and loss are fundamental issues and feelings shared by the dying and bereaved. The adaptational process in adjusting to separation and loss is circular and self-reinforcing, knowing no boundaries within the family. As the terminal patient must deal with his loss of life and family, the bereaved must deal with the loss of their loved one. How the loss is dealt with by all members of the family

system determines the quality of life in terms of enhanced or diminished functioning and mental health of the entire system.

As social expectations impose certain behaviour requirements; the individual imposes on his social context and social systems his way of coping and adapting to loss. In the family, the adjustment of the bereaved to their loss has been shown to be responsive to and affected by the death trajectory of the dying patient. Individual death acceptance forces a searching questioning of collective death denial by other members of the family. Given a particularly strong system of denial in a family, individual death acceptance can reciprocally be met with an angry, controlling response that serves to maintain the homeostasis of the status quo. Individual conformity to the values of the system is thereby linked to relationship rules and socialization transmission of socially acceptable norms, values and beliefs. Individual, family and pervasive social denial of death are then reciprocally and mutually connected in a pattern of reinforcement. In this way, the regrets, fears and sense of shame and guilt which the dying and bereaved may have about their unfinished business is transmitted through the system like a wave.

A viable hypothesis suggested by the systems approach is that if the problem of fear and denial of death is culturally prescribed and pervasive, then the natural grief process is inhibited and limited in quality. The assumption inherent in this hypothesis is that death and bereavement are a socially taboo topic much like sex once was. Gorer (1965) illustrates how the prevailing social attitude towards dying and bereavement seems to be that they are private matters that must be met in isolation by those affected. Therefore, the defense

mechanism of denial reinforces this attitude, allowing each individual, to a certain extent, to believe that: "it can't possibly happen to me." In this way for dying and bereavement to be expressed in socially acceptable terms, they are to be met with heroic, stoic, self-restraint with the open expression of emotion regarded as a sign of weakness or inability to cope.

Our social denial of death creates a double-bind by means of the injunction that dying and grief are to be hidden; yet for dying and bereavement to be resolved by effective grief work the open, shared expression of emotion and information is a prerequisite. (Bateson, G. et. al, 1956), (Erickson, R. C., 1974) The discrepancy between experiential structure and public events as suggested by R. D. Laing (1969) applies in this context. A terminal patient and his family experience the pain of psychological turmoil associated with life threatening illness. This is often exacerbated by the uncertainty, often mutually and reciprocally reinforced, between the patient and family about how they should react to each other. The impulse may be to openly give in to the overwhelming emotions stimulated by impending or occurred separation and loss. However, as a public event, the behaviour associated with dying and bereavement must be controlled. Open expression of grief is discouraged by our ritual code which demands cooperation and reciprocal agreement to help each other to perform our "face-work." (Goffman (1967) Otherwise the line of others around us is challenged. The dying and bereaved become awkward, upset and uncertain of how to respond not only to each other but to death as well. Patient and family reciprocally and mutually expect to be reassured of their own strengths and ability to handle the stress of

dying and bereavement. Men expect to be assured of their manliness; while everyone generally expects to be insulated from the reminders of their own inevitable death. We protect each other from the fear of losing our vitality and independence that usually accompanies old age. The open expression of grief and loss then amounts to a failure to measure up to the expectations of others which constitute a threat to the ground rules of social interaction. Surely such socially regarded "inappropriate behaviour" would be viewed as an indication of inability to cope, weakness, or even emotional disturbance in need of professional attention. For such disastrous consequences to be avoided, emotion must be controlled and repressed. By this means we mystify each other by misdefining the issues of dying and bereavement as those of control, restraint, and strength; instead of pain, emotion and frailty. Previous encounters with death in one's family of origin may have also provided a powerful injunction resulting in an inappropriate response to grief. In this way, a pattern of unresolved grieving could be established and passed from one generation to the next. Laing (1969, p. 3) describes this process as "invalidation:"

The set of elements that comprise the structure of events as experienced, must then not only be privately "disavowed," but must be "excommunicated" from the family dialogue. Disavowed and excommunicated, it does not cease to exist; sometimes it erupts, intrupts, disrupting the cosy chat that has taken the place of genuine dialogue. Genuine dialogues cannot occur without disclosing ourselves to each other and without according the other, and finding from the other, recognition and acceptance of how we experience one another.

Dying becomes treated like an illusion (Davidson, 1975) which does not really exist. Reinforcing and contributing to this interaction

ritual of denial, is the general medical viewpoint that death is never appropriate which presupposes an absolute dichotomy and separation between life and death. The general medical emphasis on healing as science rather than the skills necessary to work with people is an integral component of our inability to see death as part of life. Medical technology and the props associated with hospitals and medical treatment also have the effect of persuading patients and family that there will be healing, that life will be sustained. (Frank, 1973)

Science and technology have also created the prospect of imminent and total destruction in nuclear holocaust, and chemical and biological warfare. This uncomfortable forcing of death into our consciousness, however, has resulted in increasing fear of death necessitating denial so that mortality may be submerged and repressed from our field of awareness (Kubler-Ross, 1969). Family members also attempt to shield each other from the reality of death and terminal illness by not sharing a discussion of the diagnosis and prognosis or avoiding the subject altogether for as long as possible. Therefore as a family system incorporates and embodies social denial of death, the family deals with death by maintaining its secret through the avoidance mechanism of family myth and mystification. Pattison (1976, p. 38) espouses the following definition of family myth:

A series of well integrated beliefs, myth-like, which members of the family entertain about their relationship . . . The family myth is to the family what the defense is to the individual . . . The family myth is a group of defenses against disturbances or changes in the relationship.

Pattison concludes that the family myth is a neurotic mechanism for coping and maintaining homeostasis around unresolvable conflict. The

family myth in turn is maintained by the process of mystification. The family myth and mystification are in these terms the pathogenic elements rather than dying and bereavement in themselves. Pattison (1976, p. 39) offers the following description of this pathogenic process:

Mystification, as Laing (1965) explains it: "is befuddle, cloud, obscure, mask whatever is going on, whether this be experience, action, or process . . . This state of mystification is a feeling of being muddled or confused." Mystification is described by Wynne, et al. (1958) as "pseudomutuality," and by Searles (1959) as the mode of driving the other person crazy by techniques that tend: "to undermine the other person's confidence in his own emotional reactions and in his own sense of reality."

Pattison (1976, pp. 12-13) sees death denial and death acceptance as a dialectical process from which a synthesis must emerge for life and living for the bereaved to continue on a functional basis. Considering the sociocultural proscriptions against death acceptance there is little wonder that we fail to integrate death appropriately as the final stage of growth and a natural part of the life experience. The instinct for survival is strong. The dying and bereaved struggle to integrate or synthesize life with death to cope with death and dying. We shall now describe the process and efforts to achieve this synthesis and integration in terms of the fears of the patient and family during this chronic living-dying phase.

The fears that the dying experience have been defined by Pattison (1976). While he ascribes these fears only to the terminal patient, it seems more appropriate to also consider how these fears may apply to the family of the patient as well. Pattison (1976) has indicated elsewhere in his description of the family matrix of dying

and death that: "Dying is not just an individual experience; it involves the whole family Dying is not just a stress for the individual members of the family but it also impacts on the family as a system." (Pattison, 1976, p. 29) In the fear of the unknown the following issues are raised: what will I be missing by dying; if there is an afterlife what will happen; what becomes of the body after death; what will happen to my family; how will relatives and friends react to my death; will my life plans and projects be forever lost; how will my body change as I die; and, how will I react emotionally to dying. In a similar vein the family may fear: the changes that will be imposed on their lives and life-style; and what their reactions may be to the dying of their loved one which may result in awkward embarrassment and a socially unacceptable expression of vulnerability and frailty. The fear of loneliness experienced by the terminal patient is a product of a sense of growing isolation and abandonment both of oneself and others. There is a sense of depersonalization that exists for both patient and family that: "This is not really happening to me, I'm just watching." This feeling is reinforced when family, friends and frequently hospital personnel naturally begin to avoid a sick person. As Beilin (1981, p. 27) has commented: "There is an inverse relationship between mutual denial and social withdrawal, "therefore as denial and acceptance shift proportionally more from the former to the latter, social isolation increases. Contributing to this sense of loneliness is the fact that the normal interaction ritual between family and patient has been disrupted by the news of the diagnosis and prognosis. As patient and family are uncertain of what to say to each other nor how to react, resulting social awkwardness must be repaired by denial or by increasing mutual social withdrawal by patient

and family. The impact of this social isolation produces a feeling of social deprivation in a patient which is exacerbated by the strange, impersonal and often sterile hospital environment which frequently produces symptoms of confusion. Pattison has termed this combination of isolation and deprivation to be anaclitic. Elsewhere anaclitic depression has been defined as:

The syndrome shown by infants who are separated from their mothers for a long time. Initially, the infant gives indications of stress, but after three months of separation . . . the weepiness subsided and stronger provocation became necessary to provoke it. These children would sit with wide open, expressionless eyes, frozen immobile face and a far away expression, as if in a daze, apparently not perceiving what went on in their environment . . . Contact with children who arrived at this stage became increasingly difficult and finally impossible. At best screaming was illicit.
(Hinsie and Campbell, 1970, p. 201)

Pattison suggests that this depression is not the result of loss, but separation. In fear of sorrow, the dying person becomes increasingly concerned with their ability to tolerate the sorrow associated with so many losses. Pattison points out that there is an opportunity at this time for the dying person to begin anticipatory grief work so as to maximize what opportunity is left in life. Implicitly the same fear could be experienced by the bereaved family as consideration of the possibility of life without their loved one becomes painful. Fear of loss of family and friends entails the dying person reacting to the reality of losing his family almost as if they were dying themselves. Similarly family members may fear that others may no longer love them or wish to relate to them with the deceased loved one absent. The fear of loss of body is the fear of losing acceptable body image associated with a sense of self-worth. Similarly the patient's family

may fear their inability to cope with the external disfigurement or possibly the noxious odor of their loved one's apparently rotting flesh. Fear of loss of control results as the debilitating effects of disease result in diminished energy, strength and responsiveness. Disease such as brain metastases may produce a diminished level of consciousness producing a state of anxiety and fear about losing one's mind. The effects of the disease robbing the terminal patient of his former ability to provide his own physical care results perhaps in the unfamiliar sick role with its dependency and implied inadequacy.

As seen in families, the experience of bereavement can be so intense as to raise questions, for some experiencing the loss of a loved one, about their ability to retain sanity. The expression of emotion for the bereaved is fundamentally an expression of loss of control which may be so hard for them to relinquish. Fear of pain and suffering results as the disease may produce varying levels of intense physical pain for the patient. Pain control may not eliminate suffering however as relief from pain is associated with the person's attitude towards pain. The pain may be a constant reminder to the patient of his terminality which defies the defence of denial. Similarly, as the family may see their terminally ill loved one experiencing intense and uncontrollable pain their defence of denial is stripped away. Temporarily, a sense of hopeless and helpless panic may emerge. Davidson (1975, p. 44) defines "panic" as the opposite of denial as it is a frenzied search for an emotional coping mechanism which will restore some sense of order. Pattison sees fear of loss of identity as a cumulative effect of the losses and insults to identity integrity resulting from the fears previously discussed. The family

may react to the patient in an impersonal and cold manner in their anger and sense of guilt for possibly blaming the patient for leaving them to face life alone. The family identity may as well be called into question as friends and extended family avoid usual social contacts so as not to be reminded of the death and their own mortality. As the patient approaches the terminal phase of the living-dying process, fear of regression arises with the further deterioration of physical capacity and the gradual slipping away of consciousness. This may produce further suffering as the denial of death may no longer be possible for the terminal patient motivating him to attempt to hold on to reality at all costs. Pattison defines this as "death agony." The regression of the terminal patient may also provoke increased anxiety in the family as they see that the patient is dying and they are powerless to do anything about it.

As the dying person struggles with the fear of death and anxiety generated by his anticipated separation from his family, the family experiences similar social processes. They must bear not only their own grief but the grief of the terminal patient as well. The patient may with the progress of his disease or perhaps in reaction to pain relief medication, suddenly enter a stupor from which they never emerge, or experience decathexis. Fundamentally, the dying/bereavement process is reciprocal and circular. All family members are involved as a new system of role distribution, status hierarchy, and the occupation of new social positions evolves.

CHAPTER THREE

The Existential-Developmental Life Cycle View of Dying and Bereavement

I Introduction

Man is a social and political animal who experiences life and others in the process of achieving meaningful self-concept and self-realization. Man's "species life" (Fromm, 1970) consists of a number of existential predicaments or crises which must be dealt with either genuinely or falsely, congruently or incongruently by choice of the individual. Man in this way becomes his choices. Sometimes making these choices becomes an onerous, often impossible task for people to manage relying on their own resources. Death presents a situation and occasion to the terminally ill and their families in which problems solved and unsolved, deeds done or left undone, feelings of guilt, fear, loneliness, remorse, satisfaction or joy, denial, anger and depression and sometimes acceptance can be experienced in a confusing and disorienting fashion which can lead to inability to deal with death. For the patient this may mean that in addition to physical pain, the emotional pain he experiences may be just as real and debilitating. (Barker, 1969), (Fromm, 1970), (Kubler-Ross, 1969), (Sartre, 1957) May defines this "existential anxiety" as "the subjective state of the individual's becoming aware that his existence can become destroyed, that he can lose himself and his world, that he can become 'nothing'". (Kimmel, 1974, p. 498) In this way dying presents a developmental milestone for both the individual and his family which

may present an opportunity for growth, fulfillment, a heightened sense of intimacy and enhanced meaning for life.

II Coalescing Life Cycle Theory and Existentialism

According to developmental life cycle theory advanced by Lidz (1968), Erikson (1963) (1968), Haley (1971) and Kimmel (1974), it is in experiencing and mastering life crises, as presenting tasks to be met and coped with adaptively, that an individual gains personal confirmation, a sense of self-worth and is able to grow. The accompanying chart illustrates a comparison of individual and family life cycle theory from birth to death. The chart reveals that although the family life cycle of the individual and family may be labelled differently, there is a parallel in that both are faced with similar developmental tasks. Sometimes the developmental tasks can interface with one another resulting in the process of aging for individual and family becoming more difficult. It is at times like these:

Symptoms appear when there is a dislocation or interruption in the unfolding life cycle of a family or other natural group. The symptom is a signal that the family has difficulty in getting past a stage in the life cycle . . . (In this way) therapeutic strategy has as its larger goal the resolution of the problems of the family to get the life cycle moving again. (Haley, 1974, p. 74)

Moreover, from the system's point of view, if the individual is experiencing developmental difficulty, this is the result of an unspoken contract in the family to relieve the stress accompanying change and development. Thus individual developmental difficulty is symptomatic of developmental difficulties in the family. However, it is in experiencing these normal life situations that an individual gains personal

DEVELOPMENTAL LIFE CYCLE THEORY

<u>Lidz</u>	<u>Erikson (Psychosexual Development)</u>	<u>Family Life Cycle (Haley and Kimmel)</u>
Infancy	Basic Trust vs. Basic Mistrust	Courtship period
The Toddler	Autonomy vs. Shame and Doubt	Marriage and its Consequences
Oedipal Period	Initiative vs. Guilt	Childbirth and Dealing with the Young
Childhood Integration	Industry vs. Inferiority	Middle Marriage Difficulties
The Juvenile	Identity vs. Role Confusion (Emancipation of Children)	Weaning Parents from Children
The Adolescent	Intimacy vs. Isolation	
Young Adult		
Occupational Choice		
Marital Choice		
Marital Adjustment		
Parenthood		
Middle Years	Generativity vs. Stagnation	Retirement and Old Age
Old Age	Ego Integrity vs. Despair	Death of Spouse
Death		Great Grandparenthood
		Death

confirmation, a sense of self-worth and is able to grow. In this process an individual in our society relies on his primary social unit - the family - to derive personal definitions and meaning both as a child, adolescent, a parent, and as a grandparent. In these terms, death and bereavement are seen as a right of passage or developmental milestone leading to a new phase of being (or non-being) for the family. (Van Genep, 1960)

The life cycle of families and individuals is essentially a biological process of growth, stability and decline occurring simultaneously and complementarily with the psychosocial process of expansion, culmination and contraction in activities and accomplishments. In existential terms this could be seen as a process of continual emerging, becoming and redefinition of meaning or meaninglessness. Just as a flower grows from a seed, sprouts, develops a bud, unfolds, petals fall off, a seed is formed and the flower dies; so too the individual and family life cycle go through similar stages as shown in the accompanying chart. In the individual, basic trust versus mistrust, autonomy versus shame, initiative versus guilt, and industry versus inferiority are developmental tasks which must be completed, each in its own turn, if the adolescent is to form his ego identity (Erikson, 1963). Then in adolescence, one must decide for himself who, what and how he will be as an adult in the world. Sartre's description of life as a matter of choice and abandonment is crucial for the adolescent in the formation of his ego identity. For Sartre, man "is responsible for the world and for himself as a way of being. We are taking the word 'responsibility' in its ordinary sense as 'consciousness (of) being the incontestable author of an event or of an

object.'" (Sartre, 1957, p. 52) Thus Sartre sees every:

Situation is mine because it is the image of my free choice of myself, and everything which it presents to me is mine in that it represents me and symbolizes me. Is it not I who decides the coefficient of adversity in things and even their unpredictability by deciding myself? . . . (In this way) I encounter only myself and my projects so that finally my abandonment - i.e., my facticity - consists simply in the fact that I am condemned to be wholly responsible for myself. I am the being which is in such a way that in its being its being is in question. (Sartre, 1957, p. 53)

Stated more simply by Paul Tillich "'Man becomes truly human only at the moment of decision.'" (Sartre, 1969, p. 14)

Erikson identifies ego identity as "the accrued confidence that the inner sameness and continuity prepared in the past are matched with the sameness and continuity of one's meaning for others." (Erikson, 1963, p. 261) The way this dilemma of identity is resolved profoundly affects the remainder of the individual's life. With the assumption of the responsibilities of adult life, the development of a marital coalition and a family, this ego identity is nurtured, confirmed, challenged and possibly, modified. In old age, identity is attacked by the loss of friends, loss of reproductive ability, death of spouse, decreasing sense of worth, loss of the will to meaning and the eventual loss of bodily function that has been taken long for granted. Thus life's meaning and purpose is sharply called into focus with the onset of each stage of development culminating with old age. How this is handled is dependent on one's personality, which is merely a recurring way of interacting generated by force of habit. Accordingly, as Haley (1974) has asserted, crisis can be predicted to occur when

families have difficulty moving from one stage of development to another or when the family life cycle itself is disrupted. Developmental crisis then is characteristic of the human condition. In the context of dying and bereavement, the task of the social worker remains to aid the family in its maintenance of life cycle tasks. Specifically, life cycle tasks include: the formation of parental coalition, nurturance tasks, and culturation of the younger generation, emancipation of offspring from the family, family crises and adjustment to death. (Erickson and Hogan, 1972, p. 105) The existence of a very close parallel between family life cycle theory and goals for living as articulated by the modern existentialists has been cited in numerous sources. (Kimmel, 1980. Spero, 1982. Pattison, 1976. Killilea, 1980. Becker, 1975. Choron, 1964.) Accordingly clinical thanatology, as all pschotherapies, must subscribe to existential themes for living as suggested by Braaten and Albert Ellis. A list of themes would include:

- (1) Man, you are free, define yourself;
- (2) cultivate your own individuality;
- (3) live in dialogue with your fellow man;
- (4) your own experiencing is the highest authority;
- (5) be fully present in the immediacy of the moment;
- (6) there is no truth except in action;
- (7) you can transcend yourself in spurts;
- (8) live your potentialities creatively;
- (9) you must learn to accept certain limits in life. (Ellis, 1963, p. 54)

Kimmel has cited the similarity between Erikson's eighth stage of integrity versus despair and existentialism. He draws a link between the resolution of life's meaning in terms of integrity versus despair and the existential stance that: "mankind strives to find meaning in their great or mundane lives, and that the absence of a sense of meaning leads to despair." (Kimmel, 1974, p. 498) As such, a

positive confrontation with death is an experience of personal liberation important in developing an authentic sense of meaning in an alienating world. The resolution of intrapersonal and interpersonal conflicts in the terminally ill patient and the family then rests on the question of meaning, mutual and reciprocal self-definition (Kimmel, 1974) or what has been referred to as the "will to meaning" (Frankl, 1971).

The existentialist emphasis on: optimistic toughness; the awareness that emotion is not totally capricious; that man is abandoned in the world and is thereby responsible for his own fate; that thought precedes existence; discovery of meaning in suffering; and that "there is no reality except in action" (Sartre, 1957); are clearly akin to life cycle theory. Families experiencing dying and bereavement may inevitably become confused, bewildered, and disturbed by the problems and pain of their coexistence. As each step of the life cycle is encountered, the family ultimately defines itself in action by the choices collectively made by its members. Struggling to achieve and maintain homeostasis, families will necessarily resort to defensive strategies and mechanisms.

The model of health implicitly proposed by Sartre is that man must be able to make choices in the definition of his life, assume responsibility for his choices and accept responsibility for others as part of his process of self-definition. To change, man must take the initiative and make the choice to confront the anguish and despair of his freedom to define himself and with an optimistic toughness, negotiate the subsequent choices that arise therefrom. Pathology then, in a general sense, exists only in as much as man abdicates his

self-responsibility by surrendering to the tide of events rather than initiating them. With existential anxiety man is thereby regulated by his environment instead of by himself. In terms of existentialism:

Death provides ultimate freedom not in the moment of surrender to death, but in the 'One finds meaning in life when one is committed to something for which one is willing to accept death.' 'The confronting of death gives the most positive reality to life itself. It makes the individual existence real, absolute and concrete. For "death as an irrelative potentiality singles man out and, as it were, individualizes him to make him understand the potentiality of being in others . . . when he realizes the inescapable nature of his own death.' Death is, in other words, the one fact of my life which is not relative but absolute, and my awareness of this gives my existence and what I do each hour an absolute quality. (Spero, 1981, p. 38)

Erikson's eighth stage of ego integrity versus despair can be reached at any time when the dying person confronts his own death. In this stage the dialectical struggle between two dichotomous opposing tendencies are both equally possible outcomes. Death imposes an absolute state of non-being. Successful resolution of this stage involves looking back over one's life and examining the question of the meaningfulness of one's life, how one's life intersects with history, and a sometimes excruciating choice and judgement of whether one's life was actually worth living. If this examination of one's life yields the conclusion that the time is too short and it is too late to change a meaningless life in major ways, despair can ensue. This concept of despair bears marked resemblance to May's description of existential anxiety and Laing's description of ontological insecurity. An ego integrity crisis then can develop:

When one's 'review' reveals lacunae; when the individual cannot accept death in some meaningful, non-defensive manner; when the anticipation of death conjures up only loss, separation and grief rather than fulfillment, accomplishment and love; when the imminence of death illicitly regression to infantile illusions. (Spero, 1981, p. 39)

The confrontation with death, however can have an emerging positive value of wisdom, which Erikson defines as "accumulated knowledge, mature judgement and inclusive understanding." (Erikson, 1968, p. 140) This positive resolution of the dialectical conflict subsumes, embodies and recapitulates all of Erikson's stages.

The parallel with existential thinking lies in that in both the developmental and existential view, the overriding and primary goal is to find meaning in existence, and that absence of meaning leads to the despair which is in itself grieving for the loss of an opportunity, for things that might have been. Kimmel suggests that these fundamentally profound issues become of primary importance not actually when death is imminent but when a developmental milestone is turned in midlife. A period of self-assessment occurs in the midst of the transition between the contradictory life cycle tendencies of growth-expansion and contraction. Kuhlen sees this process as being initiated in itself by a single or perhaps a series of irreversible losses ranging from physical illness, family breakdown, death of friends or loss of job opportunities. This in turn results in a qualitative change in life by which the focus shifts from time elapsed from birth to time left until death. (Kimmel, 1980)

The existential approach suggests that there is no objective standard of human nature as there is no God to prescribe and define it. There is only existence and the will to be which defines us. Man

becomes his choices otherwise there is nothingness. Existence is therefore tied to will and is totally free. It is a categorical imperative, there is no freedom not to choose to define one's self. One cannot not choose. The fundamental choice is between ego integrity versus despair. As such "man is condemned to be free," but in that condition man is responsible for everything he does without exception. Man is then also responsible for others as in relating to others man defines himself in totality and either inflicts the pain of, the nothingness of, or the enjoyment of a meaningful social situation upon himself. Freedom is a mutuality. (Sartre, 1957, pp. 16, 18, 46) Sartre asserts that in thrusting towards freedom we discover that our freedom is defined entirely by the freedom of others and the freedom of others is entirely defined by our own freedom. Becoming aware of his condition man defines himself in his actions and by acting imposes values. Freedom is then the basis of all values and the only reality is action. The optimistic toughness imposed by existentialism leads to rebelling against meaninglessness as man must act and struggle to experience life fully if he is to be real and not absurd. Thus the emphasis must be put on experiencing - in the sense of the present tense - in the here and now. To place emphasis on experiences would be to exist in the past by focusing on peak experiences. With the emphasis on experiences apathy and indifference to an often grim set of circumstances results. Life is then a matter of choice and man becomes his choices. Man's humanity and achievement of meaning then exists only in so much as he participates in the life of his community and associates with self-assertion and struggling to satisfy his will to meaning or ego integrity. (Laing, 1974)

CHAPTER FOUR

The Crisis Aspect of Dying and Bereavement

I Introduction

Contrary to the view of crisis intervention (Aguilera, Messick, 1978) (Golan, 1978) which sees dying and bereavement as situational crisis; given the previous discussion of dying and bereavement in terms of existential and life cycle theory, it seems more appropriate to consider dying and bereavement as developmental crisis. This is the view shared by much of the death and bereavement literature. (Kubler-Ross, 1975) (Pattison, 1967) (Kimmel, 1980) Labelling of dying and bereavement as situational crises, could only possibly be considered appropriate and accurate for situations where death is accidental and unanticipated. If one accepts the notion that death is part of life, death then fundamentally belongs to life whether it be an unanticipated misadventure or not. Death as the result of prolonged illness, which is the subject of inquiry here, is therefore by any consistent definition, a developmental crisis. Despite disagreement over this use of labels, the viewpoints expressed regarding death as a situational crisis are nonetheless pertinent to our discussion of dying and bereavement.

Crisis literature and crisis theory have developed from the work of Lindemann and Caplan, two of the many writers in the area, in their study of bereavement and reactions to death. (Golan, 1978) Parad and Caplan (1960) view the whole subject of crisis in human existence as occurring and operating on three, systematically involved

and mutually related levels or perspectives. They define the levels or processes involved as intrapersonal, interpersonal and transactional. By this is meant that an individual's disturbed state of equilibrium and functioning will inevitably, and interpersonally, affect those about him. Those about the individual in crisis whether they be friends, family or work associates will not only find that the content of their relationship is affected, but also transactionally, the processes of relationships will also be affected. This does not imply that crisis is fundamentally an intrapersonal state of being in disequilibrium which secondarily affects the content and process of relationships. Every situational crisis which results in a change in the functioning of that individual means that this change will ripple or reverberate through the social systems of which he is a member. As Erikson has pointed out and has been discussed earlier, at certain predictable times, families and their members are subject to crisis, turning points or milestones in their development. Moreover, Rapoport (1970, p. 274) has commented that crisis theory is applicable to the individual, family and group.

II Crisis Theory

Aguilera (1978) and Golan (1978) have both commented that the Chinese characters which taken together represent the word crisis can be interpreted to mean both danger and opportunity. Fundamentally this is the nature of crisis. Crisis provides an opportunity to establish new coping mechanisms in a situation or life context which may be experienced time and time again. In this way, crisis can enhance adaptational capacity and in Darwinian terms could be described as a process of natural selection. (Pollock, 1961, p. 342) Crisis can

produce a higher level of functioning than that previously attained, increased functional stability for the system in terms of improved mental health for both the patient and his family. Conversely, the crisis can lead to a lower level of functioning and diminished level of mental health. (Parad, 1965, p. 26) However contrary to crisis theory as stated by Rapoport (1962) and virtually every other writer on the subject of crisis, the resolution to the crisis state fundamentally cannot lead to the prior level of functioning or equilibrium. In the context of chronic, fatal illness, the family system can never operate qualitatively in the same way it did prior to the death of its ill member. In common with all other developmental or situational crisis however, it is imperative that the family system find some solution to the crisis. As Watzlawick (1967) has commented: "One (the system) cannot not react."

Basically, crisis theory suggests that there must be a hazardous event, stressor or precipitant which puts the individual/family experiencing it in a vulnerable state as tension rises in response to the initial impact of stress. Previously used coping mechanisms are operationalized and tested. The individual/family subjectively reacts to the hazardous event as a threat, a potential loss or as a challenge and becomes unable to master the situation. Anxiety, mourning or depression result if the usual coping mechanisms fail to meet the demands of the active crisis. Hill (Parad, 1965, p. 36) suggests that: "A (the event)--interacting with B (the family's meeting resources)--interacting with C (the definition the family makes of the event)--produces X (the crisis)." The experience can also reactivate earlier unfinished business which compounds the difficulty. Old conflicts

symbolically are linked to the presenting problem in terms of their common characteristics of either being threats, losses or challenges. As this experience occurs, the client system's sense of demoralization, helplessness, and powerlessness becomes compounded. In this way, repressed unresolved psycho-social crisis and weaknesses are reopened, exposed and their resolutions are found to be inadequate. Thus there is a relationship between the completion of different developmental tasks and later life situations which symbolically call up the old conflicts of the preceding tasks. As has been discussed in the existentialism and life cycle theory section of this paper, developmental stages are mutually dependent. Failure or inability to complete some or few of these tasks in any of the initial stages of development will be reflected in inadequate performance of the developmental tasks of the later stages. As Erikson (1963, p. 274) explains:

The assumption that on each stage a goodness is achieved which is impervious to new conflicts and to changing conditions is, I believe, a projection on child development of that success ideology which can so dangerously pervade our private and public day-dreams and make us inept in a heightened struggle for meaningful existence . . . The personality is engaged with the hazards of existence continuously even as the body's metabolism copes with decay. As we come to diagnose a state of relative strength and the symptoms of an impaired one, we face only more clearly the paradoxes and tragic potentials of life.

Rapoport (1962), in agreement with Caplan has asserted that crisis usually lasts from one to six weeks. In terms of chronic, fatal illness the period of crisis may be prolonged into months and possibly years. The disease may be very slow in progressing and the patient and his family may not cope successfully and adapt to a higher level of functioning when initially confronted with the disease. When new

developments in the progress of the disease occur, the family may be repeatedly thrown into another state of crisis which is basically an indication of failure in resolving the life crisis initially. Hill (Parad, 1965) has suggested certain factors and processes when taken together, produce a state of crisis proneness. Hill suggests that crisis proneness be understood in terms of his previously discussed crisis formula:

Crisis proneness is in effect the phenomenon of experiencing stressor events (A) with greater frequency and greater severity and defining these (C) more frequently as crisis. In other words, crisis prone families appear to be more vulnerable to stressor events . . . , and more likely because of meagre crisis meeting resources (B) and failure to have learned from past experiences with crisis, to define these events as crisis provoking. The explanation for crisis proneness therefore lies primarily in the B and C factors in our equation. (Parad, 1965, p. 40)

Simply stated, a family experiencing the chronic illness of one of its members may simply be worn out by the pain and depression produced by loss or threatened loss of their loved one to be able to cope adaptively with a new situational crisis or the further progress of the disease. The family also may not have successfully dealt with the crisis initially by denying the reality of the situation and continuing to do so. Such a family's ability to maintain their denial would be severely tested with the progress of the disease. Various factors in the progress of the disease could produce another in a series of episodic crisis if the dying family member should experience intractable pain, become confused or lapse into unconsciousness and thereby be unable to relate as they formerly had. In crisis theory, if the state of crisis persists and fails to yield to previously used

coping mechanisms or emergency, untried ones, the person/family can become particularly amenable and open to help. The final stage of crisis theory is a period of reintegration which is marked by the learning of new adaptive, coping styles which can be transferred to other situations. As previously mentioned, if the person or family in crisis needs but does not receive help, inadequate or maladaptive coping patterns can result which then produce weakened coping ability which limits functioning, leaving the person more susceptible to further crisis. (Golan, 1978)

Definitions of crisis have been suggested. Rapoport (Parad, 1965, p. 24) has suggested that crisis: "is a call to new action . . . (or) 'an upset in steady state' . . . (in which) the habitual problem-solving activities are not adequate and do not lead rapidly to the previous achieved balanced state." Caplan suggests that "a crisis occurs when a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of his customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made." (Aguilera, Messick 1978, p. 6) Another definition of crisis, suggested by Caplan, offers the most satisfactory, comprehensive definition of crisis:

A crisis is a period of disequilibrium overpowering the individual's homeostatic mechanisms. During a crisis a person is faced by a problem which, on the one hand is of basic importance to him because it is linked with his fundamental instinctual needs, and on the other, cannot be solved quickly by means of his normal range of problem-solving mechanisms. (Parad, 1965, p. 56)

III How the Crisis Occurs and Evolves

Many potential crisis situations arise in the complex experiences of dying and bereavement. Initial awareness of the terminal prognosis, the emergence of new fears, the death itself and many other circumstances in the living/dying process may develop into crisis. These hazardous situations threaten the patient and survivors with pain in anticipation, or the fact of separation and loss. Not every family that experiences dying and bereavement associated with chronic, fatal illness will find itself in a state of crisis. As Hill (Parad, 1965) has suggested, whether or not a situation is a crisis will depend on the definition that is made of the event. However, the definition of the event also depends upon the crisis meeting resources and coping mechanisms available to the individual/family. Few people die or experience bereavement because they premeditate, plan or want the experience. In actuality, the opposite is true. The event of dying and death is inevitable but is also inevitably met with denial. The positive social function of denial has been discussed previously as has inappropriate denial. The suggestion has been made that in crisis the individual becomes more receptive than usual to help as defense mechanisms become weakened. However, the taboo of death and socially prescribed denial of the event frequently obviates and prevents this openness in the bereaved. Consequently two factors operate to generate crisis in dying and bereavement. First, the event may not be resolvable for those concerned based on their past repertoire of coping patterns. Second, denial may prevent those concerned from reaching out to professionals for help. The situation may also result in everyone concerned feeling uncertain and awkward about how to respond to each other.

The silence of denial may be reinforced when the dying patient and their loved ones do not know what to expect of each other, how to react to each other, nor how to reach out to each other. Conversely, patient and family may attempt to protect each other and themselves by becoming enmeshed in conflict. Blaming and rejecting can symbolically become an attempt to deal with the dying/bereavement developmental crisis in an easy, indirect way. The pain of separation through death and the uncertainty of how to confront the issue are thereby avoided at least temporarily. This type of relationship vacuum can lead to intrapersonal and interpersonal alienation in the family as invalidation and mystification deny the reality. The crisis of dying and bereavement can take many forms depending on the family history, relationship rules in the process of communication and patterns of information-sharing.

Dying and bereavement in chronic fatal illness may seem to present an irresolvable crisis for the patient and/or family. The terminally ill patient cannot solve his predicament--only learn to live with the inevitability of his death. The family cannot replace a loved one. The family can also not return to its prior level of functioning or function in the same way that it once did, with a missing member. They must learn to live with their loss and form new relationships. Added to this instinct of self-preservation which dictates that life must go on, is the depression experienced by the patient. The stress of the dying process and the concurrent adaptation to the impending loss can sometimes lead to a questioning of loyalties. Family ties can become strained if the pace of adaptation to the loss is not uniform across the system. Delay in the adaptation

can lead to continuation of reactive depression resulting in loss of support systems needed for the adaptation. Lack of decision and initiative can be detrimental to continued social and economic existence. (Lindemann, 1944, pp. 145-146) Crisis may occur if the regression in bereavement referred to by Spiegel (1977, p. 77) threatens the performance of necessary tasks or duties.

Pattison (1967) has suggested that death is a crisis event and can be understood in the clinical terms of crisis intervention therapy. The approach taken by Pattison is to examine how one faces death and goes about the process of dying. Pattison concludes on this basis that while we cannot deal with the ultimate problem of death and cannot change that, we can help the person deal with the various parts of the experience of dying. Pattison sees death as a crisis event characterized by five criteria. (Pattison, 1967, pp. 34-35) First, the experience of dying imposes a problem which by definition, is insoluble. Death however, is particularly stressful as it is an event which must be adapted to rather than overcome. Second, one's own death is beyond traditional coping mechanisms as without prior personal experience to rely upon, other than the experience of the death of others, the innovation of new problem-solving methods is forced. Third, the experience of dying threatens the life goals of the dying person and deprives the individual of their attainment. Fourth, when one learns of his impending death, tension and anxiety mounts to a peak which can be responded to by: the mobilization of coping mechanisms and dealing with the anxiety; or by disorganization as overwhelming anxiety is experienced. With either outcome the anxiety usually peaks much before death, diminishing as death becomes more imminent. Fifth,

dying reawakens the inevitable past conflicts of life and unfinished business including dependency, passivity, narcissism, inadequacy, identity and many others. While Pattison reserves his description of death as a crisis for only the dying person, however, similar crisis provoking effects can be seen to apply to the family as has been previously described. In terms of Pattison's criteria, the death of any family member will reactivate old conflicts and crisis, question the nature of the past relationship, and how one's life has intersected with the dying loved one. Fundamentally again, as for the dying person, the bereaved are faced with a situation to which they must bow rather than solve.

Dying and bereavement may overwhelm the patient or family. The family may become disorganized and begin to function ineffectively. To the stimulus of the hazardous onset of the disease, the patient and/or the family may respond with certain maladaptive coping patterns which are counter-productive to the resolution of their crisis situations. Rising tension may induce a response of magical thinking, excessive fantasy, regressive behaviour, somatization, or psychosis. (Rapoport, 1962) Normal and atypical grief have been discussed previously. Certain family processes and operational styles however may indicate a family in trouble. A family which abandons itself to the vicissitudes of fate particularly in times of stress could experience serious difficulties adapting to death. Such families have a here and now orientation to the extreme that they disregard the consequences for living that their situation imposes upon them. Families such as these are faced with the choice of mastering their situation and defining themselves individually and collectively or symbolically dying themselves by giving up and allowing themselves to be defined by events. A

family structure of this kind processes events through the use of group denial mechanisms by failing to foresee consequences that may produce stress. Such families are prone to impulsive reaction which can have a positive result but which can also produce a profound crisis reaction and self-alienation. (Parad, 1965, pp. 40-45) Families that are also solitary with little external support systems in terms of relatives, friends or neighbours may also experience serious difficulties. This type of family could be said to be inner-directed rather than outer-directed which is the antithesis of the position that man defines himself in action and in relating to others. Rapoport (Parad, 1965, p. 29) has suggested that for individuals and families, a healthy response to crisis and a similar resolution could be described by:

(1) correct cognitive perception of the situation, which is furthered by seeking new knowledge and by keeping the problem in consciousness; (2) management of affect through awareness of feelings and appropriate verbalization leading toward tension discharge and mastery; development of patterns of seeking and using help with actual tasks and feelings by using interpersonal and institutional resources.

With specific regard to bereavement, Hill (Parad, 1965, pp. 46-47) has suggested that a generic pattern of adjustment to bereavement in families to crisis consists of disbelief, numbness, mourning, trial and error adjustments, renewal of routines and finally recovery.

Parad and Caplan (Parad, 1965, p. 56) suggest that a framework for assessing individual mental health and adaptability to his environment considers:

The individual's ability to (1) initiate and maintain satisfying emotional relationships with others, (2) work productively and fulfill inner resources, (3) perceive reality undistorted by fantasies, and (4) adapt to his environment if this is conducive to his welfare, in a way that impinges minimally upon the rights of others.

On the level of the family, Parad and Caplan (Parad, 1965, pp. 62-71) also suggest a framework for assessing the adjustment of families to crisis. The life-style of the family, the family's intermediate problem-solving mechanisms, and the need response pattern of the family to the basic needs of its individual members are considered. Assessment of family life-style involves evaluation of the family's value system, communication network, and role system. The responsiveness of each of these elements to the crisis situation in a congruent yet innovative and novel manner determines the efficacy of the family's life-style. Intermediate problem-solving mechanisms are seen as the family's life-style in action in response to the stimulus of the crisis situation. A trial and error approach to dealing with the event results in a variety of new coping mechanisms being tested. This element of a family's adjustment to crisis will either have a growth-promoting or growth-diminishing effect on the family's collective mental health. The family's need response pattern dictates the extent to which the family's members have their basic mental health needs met. Parad and Caplan suggest that this element can be measured across several dimensions. Included are the ability of the family's members to reach out to each other with unconditional love, the degree to which a balance is achieved between support and independence tasks, the degree to which a balance is achieved between freedom and control in terms of individual expression and lastly, the availability of suitable role models.

This discussion does not assume nor imply that everyone requires intervention from professionals such as social workers to cope successfully and functionally with dying and bereavement. Dying and bereavement in any life trajectory (Pattison, 1976) is not necessarily a pathological process. Death and dying are natural processes and are as much a part of life as birth. Therefore, a major task of helping professionals in the care of the terminal patient and his family is to distinguish client systems that are in need and those that are not. This distinction has already been described in chapter two.

These frameworks of individual and family adjustment to crisis, (although they have not been empirically validated) suggest that they may be utilized in assessing the need of the dying and the bereaved for therapeutic intervention to assist them in overcoming the obstacle(s) encountered to healthy resolution of their crisis. In this way the goals of intervention can be specified, focused and achieved. In this process the challenge to the social worker is, to respond professionally without personal bias. As has been discussed earlier, what may appear to be extremely inappropriate reactions to dying and bereavement, may in fact be an understandable and congruent response to the ideology of the client system's history and life-style.

CHAPTER FIVE

Intervention

McKitrick (1981) following the work of Bard, and Kastenbaum and Aisenberg, suggests that there are four ways of relating to dying and death: overcoming, participating, fearing, and sorrowing. While McKitrick's work has some rather obvious limitations, in that he mis-categorizes some approaches and neglects the family centred approach totally, his categorization of four ways of relating to dying seem to be a useful way of organizing the literature.

McKitrick suggests that the foremost approaches to overcoming one's death are suggested by a psychoanalytic approach, a crisis intervention approach, with the treatment focusing on the client's feelings of loneliness. The psychoanalytic approach, according to McKitrick, offers clients a choice of two options to overcome death. When clients do not openly acknowledge that they are dying, Eissler (1955) suggests the therapist help the client maintain their fantasy of immortality while at the same time providing them with support to endure the process. On the other hand, clients who openly acknowledge that they are dying are offered the therapist's supportive companionship in an attempt to fend off negative aspects of the dying process. This approach seems to unquestioningly attempt to follow the prevailing cultural stereotype of death and dying as something that is not essentially a part of life that is to be resisted at all costs so that one may triumph over death. This approach seems to be inherently dishonest as it does not confront the reality of death and its finality. McKitrick suggests that the crisis

approach to dying and bereavement is advanced by Pattison (1976). Pattison's approach and work has been discussed earlier as a way of understanding the varying reactions to death. However, Pattison suggests not only how to deal with specific reactions to the process but also suggests how the process may be integrated with the meaning of the dying person's life to achieve an "appropriate death." McKitrick's deliniation of Pattison's work up to this point is accurate but it ignores Pattison's work on "the family matrix of dying and death." The fundamental point that Pattison makes in his consideration of how a family gives meaning and form to death, is his identification of death as part of life and therefore is not purely suggesting that death is something that must be struggled against and overcome. Instead, Pattison as we shall see later is suggesting that family participation in the dying process and in bereavement can be in itself how the family overcomes the death. McKitrick suggests that Schoenberg (1970) identifies loneliness and isolation as the primary problem which the dying face as the patient and their family naturally withdraw from each other. Schoenberg seems to restrict his approach primarily to the dying patient in terms of offering the patient support so that they may live as totally and meaningfully as possible during their dying. Schoenberg's approach seems to have a very narrow focus which views the dying patient as someone who can potentially emotionally live as a separate autonomous being without reference to the role of the family in the dying patient's ability to cope with the process.

In a participative way of relating to death, McKitrick identifies patient-centred and self-actualization approaches. The patient-centred approach was advanced by Feigenberg (1975) as a purely individual-centred

psychotherapy. The importance of a strong therapeutic relationship characterized by trust, empathy, genuineness and respect is emphasized. A non-directive stance is assumed by allowing the client to determine the direction and pace of counselling. Feigenberg suggests that contact between the therapist and families must be severed at the beginning of contact with the patient to facilitate the breaking of emotional ties which inevitably occurs in the dying process. The self-actualization approach suggests that clients be shown how to use their dying as part of a growth process which in essence focuses on attempting how to treat and teach clients to live as they die. This is essentially a holistic approach which suggests that emotional well-being can affect the progress of the disease such that the dying patient can be eased through the experience. This process must deal with patterns in the patient's life-style and his search for meaning. Taken together, the patient's will to live may be rekindled, allowing maximization of their living before death occurs.

Rosenthal (1963) suggests that fear of death is an indispensable factor in all psychotherapy and is the primary issue which must be addressed in psychotherapy with the dying. Once this issue has been dealt with, Rosenthal then suggests that the goal of therapy becomes to understand and inculcate understanding in the dying patient of his past life-style and to resolve the patient's negative feelings about himself. Rosenthal attributes these negative feelings to the patient's feelings of guilt arising from his patient's past life which may be manifest in self-destructive wishes and a yearning for death as just punishment for his past. Rosenthal describes this as the "tragic guilt" feeling which will be resolved if the counsellor and client

develop insight into the client's past life-style which will then reduce guilt and fear of death. McKitrick proposes that another way of counselling dying clients is to focus on their sorrow or "anticipatory grief." The work of Goldstein and Malitz (1974) suggests that this approach comprises the selection of a task by the counsellor to structure the relationship with the client. The counsellor must then be aware of the emotional content the task assumes because of its association with the coming death. The counsellor should also not induce discussion about death, the counsellor should instead respond to the client's need to talk about dying if it should arise.

McKitrick concludes by discussing "the stage theory" which he attributes to Kubler-Ross (1969). As previously mentioned, Kubler-Ross describes the processes of denial, anger, bargaining, depression and acceptance. McKitrick sees Kubler-Ross as depicting these processes moving in a sequential and linear fashion from denial to acceptance. As we have discussed earlier, this would seem to be a serious misinterpretation of the approach suggested by Kubler-Ross. McKitrick indicates that he did not include the work of Kubler-Ross within any of the categories of reactions he suggests, as her approach does not seem to fit any of them. This observation in itself seems to suggest that McKitrick failed to understand Kubler-Ross as she does not propose that all patients must experience each phase of the dying process or that one stage will deterministically follow the other. Neither does Kubler-Ross attempt to focus her treatment upon moving the dying client from stage to stage so that they will eventually reach acceptance. Instead Kubler-Ross proposes a non-directive approach which keeps pace with the client's capacity while attempting to deal

with the process the client is experiencing. She does this by listening to the client's symbolic non-verbal language as well as to what they are saying.

McKittrick also does not take into account behaviour therapy in terminal care as advanced by Sobel (1981). Behavioural therapy is in part a reaction to the popularized misunderstanding of the Kubler-Ross approach. Sobel suggests that the approach taken by Kubler-Ross emphasizes mere "being with" the dying patient. Instead Sobel suggests that the therapist must be actively involved in a consultative and educative role to assist the patient in regaining self-control while dying by suggesting a new approach to the developmental task of living in the face of death. Sobel suggests that this approach is inherently more humanistic as it centres on what the client wishes to work towards during the dying process rather than deterministically fitting clients into a preconceived notion of dying and forcing them to accept death. However, Sobel also seems to be distorting the Kubler-Ross approach. Kubler-Ross clearly sees death as the final stage of growth and implies that she does not expect that every patient will accept death. She also acknowledges that it is not necessarily desirable that every patient accept death. Neither does she suggest the patients be forced from one stage to another. What Kubler-Ross does propose is that, not only must the medical needs of the patient be met; but the patient's emotional and social needs as well.

Another approach to intervention in dying and bereavement is what may be called the family-centered approach. From the literature, it is clear that Kubler-Ross (1969), Pattison (1976), Bowen (1976), Paul and Grosser (1965), Lloyd (1977), Orcutt (1977), and Arndt and

Gruber (1977) are perhaps the leading proponents of this approach. This is primarily the approach taken by this social worker in working with patients and their families experiencing dying and bereavement. It seems that this process is however an eclectic one, as the process is also patient-centered, self-actualization-oriented and crisis-oriented. This family-centered approach seems to be humanistic in its orientation. Its basic assumption is that the client's primary social unit is his family which must be involved as much as possible to enhance the dying patient's coping and living experience in the face of death. The goal of this approach is essentially to facilitate the adjustment of patient and family by role modelling a congruent, concrete and meaningful response to the dying process. Another assumption of this approach seems to be that it is ideal for the therapist to become involved with the family as a whole before the patient has actually died. It should be pointed out that Pattison restricts his view of the family matrix of dying and death to involvement with the family only after the death has occurred. However Pattison does cogently describe the processes of family myth and mystification. These processes help maintain our cultural denial of death and allow the family to maintain a superficial sense of equilibrium in the face of a crisis of death and dying. The "groupthink" phenomena operates such that each member of the family looks for cues from the other members of the family as to how they should react and where the limits of socially acceptable response to grief are located. Pattison also points out the existential basis of dying and bereavement and adjustment to loss:

Our existential view of death is also our view of life. If we cannot admit death is part of life, may

it be that we cannot face the fundamental psychological issues of separation and individuation that contains the kernels of loss? Therefore, I suggest that the management of death in the family is rooted in the basic management of object relation separation and loss in the family, which in turn is a reflection of the existential death position of the family. (Pattison, 1976, p. 40)

Lloyd (1977) has discussed the importance of the resolution of grief and the double bind that is presented to families. Cultural prescription calls for death to be denied, contained, proper and attenuated. However, for healthy resolution of grief, the reverse is required. Grief must be expressed openly, honestly and must be shared. Orcutt discusses the importance of a family meeting as a way of ending the "moratorium on communication" in the family to promote a "reciprocating-empathic responsiveness" in the family. Arndt and Gruber discuss family patterns in coping with dying and bereavement and suggest that tasks the family performs parallel the tasks of individual family members.

Paul and Grosser (1971) have suggested the technique of operational mourning in conjoint family therapy. Paul and Grosser suggest that the experience of loss can be passed down transgenerationally such that incompleting mourning experienced by a member of one generation results in the creation of a pervasive defense against further losses and disappointments. This reaction can be passed down from parent to child, resulting in a family life-style which attempts to deny or "ward off" losses and disappointments. Therefore major changes in family situation such as, a new birth, emancipation of offspring or a death in the family reawaken the sense of threat imposed by the previous loss. In this way coping with death is seen to be a very important

developmental task for future functional and congruent living. As Paul and Grosser comment, the transgenerational transmission process illustrates the existential view of the quality of life. In these terms, the dying, to the extent of the time they have left to live, and the bereaved can condemn themselves to pain and alienation by refusing and fearing an open, honest confrontation with their reality. Therefore the dying and bereaved can be seen to define their existence, position in the family and capacity to live fully in a larger community by their behaviour and action. This approach very closely fits with the approach of Kubler-Ross in which she attempts to help the dying patient and family to deal with their unfinished business so that they may get on with life, to the extent that is available to them, without the subconscious shackles of the "But I didn't" regrets.

Bowen (1976) suggests the chief taboo subject in our society is death. This taboo is partly maintained by the automatic reflex of closure of communication in the social system of a family. The family that begins with a more or less closed system of communication will shift their relationship toward an even more closed system to avoid sensitive subjects such as dying and bereavement. Bowen suggests also that death can frequently be the precipitant of an emotional shock wave in the family which may be carried by a multi-generational transmission process from parent to child. The family projection process will then scapegoat one member of the family so that person becomes the focus of the stress and the tension created by incomplete mourning or other serious events. In this way a sense of balance and equilibrium remains in the family so that it can function on some level. Emotional enmeshment then results in the family as a function of the

degree of differentiation of self that is operative. This concept refers to the degree of fusion or differentiation between emotional and intellectual functioning. Where grief work is incompleting, unfinished business results, inevitably affecting the relationship patterns in the family. The effect of unfinished business may not be clear, however, until the next generation of the family. For the multigenerational transmission process to occur, the relationship rule, (Watzlawick et al, 1967) which reinforces the denial and shields against awareness of the incompleting grief work must be projected by the family onto one of its members. The family then develops the perception that the deviant family member must change as he does not fit the family's value system or behave as is considered appropriate. In fact, this family member is the symptom-carrier of the family dysfunction which threatens the family myth and the mystification inherent in the multigenerational transmission process. Working with families displaying this type of dysfunction entails problems of engagement if the family feels they are being stigmatized and victimized by a degradation process in being the recipients of help. Then if the pace of therapy should be too fast, the family will terminate involvement as their conservative impulse (Marris, 1975), reflexively activates. This reflex response is indicative of the family's attitude towards change and their preference for the familiar versus the comfortable. The familiar is at least a way of functioning that they know which they will automatically prefer to a way of functioning that is both unknown and foreign. Taking these considerations into account, it seems that the families most in need of help are likely to be those experiencing dying and bereavement simultaneously with another major

developmental milestone. The tell-tale effects of the emotional shock wave of previous bereavement experiences or serious losses in terms of the current life-style of the family may also be a prime indicator of the need for help.

Essentially, the family-centered approach is humanistically and ecologically oriented. Dying and bereavement are first of all normal developmental milestones and as such every family will not require some form of professional help in dealing with the death and bereavement. The approach also begins where the family is and proceeds at the pace that they are capable of sustaining. Holistically, the medical as well as the emotional and social needs of the patient and family are given equal consideration. The non-directiveness of the approach enables the client to choose for themselves the direction of the therapy rather than having to accede to a preconceived notion of what dying and bereavement should resemble. In attempting to involve as much of the client's social system as possible, the social worker is utilizing the family as the means and modality of treatment. In this way it is assumed that the family is capable of correcting itself if given the opportunity to deal with the unfinished business. Specifically how this is affected is basically very simple. First, the health care institution itself can do many things in terms of its organization of staff, physical setting and adherence to a holistic approach to open a family's closed communication system. Implicitly, the message may be given that death is part of life and while there will be loss in grief, the possibility of growth remains. Secondly, the social worker must always begin with what the family has already been told about the diagnosis by the physician, assuming of course that the physician

himself has not become a part of the closed communicational system. Third, the social worker must be honest about the process while acknowledging the pain inherent in dying and bereavement. This is done by using the words death, dying, bereavement, bury, funeral, life, and encouraging a life review process. Fourth, the social worker must be aware of his own reactions to the reactions of the dying patient and family to avoid being seduced into reinforcing the closed communication system of the family.

The resolution of inner and outer conflicts in the terminally ill patient and family rests on the question of meaning or what has been referred to as the will to meaning. According to life cycle theory as it has been presented here, it is in experiencing and resolving these life conflicts that an individual gains personal confirmation, a sense of freedom, a sense of improved feelings of self-worth and is able to grow. The model of health in dying and bereavement suggested here is that man must make choices in the definition of his life, assume responsibility for his choices while accepting responsibility for his loved ones and the larger community as part of his process of self-definition. To change, man must take the initiative and make the choice to confront the anguish and despair of his freedom to define himself and with an optimistic toughness, negotiate the subsequent choices that arise therefrom. Pathology then, in a general sense, exists only inasmuch as man abdicates his self-responsibility by surrendering to the tide of events rather than initiating them. This is existential anxiety in which man is regulated by his environment instead of by himself. Death then provides an ultimate opportunity to grow and extend one's self to achieve a sense of freedom that could not

otherwise be attained. At the time of death, there is no further reprieve for the dying patient. Either at that point they will deal with their unfinished business or they will take it with them to their grave. For the family, the occasion of the imminent death of their loved one gives them a last opportunity to say the things that they may have wanted to say but may have been unable to say. If the opportunity is passed by, it will never come again. The resolution of unfinished business is still possible although more problematic as the immediacy of the experience is lost. Death then, can give a positive present orientation to life which a client's system may never otherwise be able to attain. As such, a positive confrontation with death is an experience of personal liberation important in developing an authentic sense of meaning in an alienating world. This is the existential model of health based on an understanding of death and dying suggested in this paper.

From this viewpoint, the interventive strategy then, has been to maximize the health of self-help capacity of the terminal patient and surviving family by providing a permissive, supportive therapeutic milieu intended to open the client's communicative system. A very closed communication system helps a family maintain their mystification process that attempts to "ward off" losses, grief and disappointments. This false sense of security breeds a fusion of emotional and intellectual functioning resulting in a lack of awareness of difficulties. Therefore, a primary task for social work is to help families identify their unfinished business so that their creative energy can be released to achieve a higher level of functioning. Encouraging initiation of planning, a sharing of life review and the open expression

of grief are the main ways of achieving an opening of communication and identification of unfinished business.

The difficulties inherent in this approach are not to be minimized. It may not always be possible to work successfully with every family. As this is the case, the creation of a permissive total atmosphere in the health care institution involving the physical setting and the function and orientation of all staff can in itself achieve some reopening in a totally closed communication system. The effect of social work involvement in helping dying patients and their families cope with their reactions to dying and bereavement can then be maximized as the stage will have been set for the opening of communication.

CHAPTER SIX

Practicum Overview

I Clinical Summary

The terminal care program of the St. Boniface General Hospital provided the clinical setting for this study. This writer provided a social work service to eight families drawn from some component parts of the terminal care program. Included were three families in which the patient was at home and receiving Home Care services. For this group, admission to the terminal care ward of the hospital (hereinafter referred to as 2ECU) was available on a priority basis as needed. Such admissions could result from deterioration of the patient's condition or care management problems. Four families had members who were inpatients of 2ECU. The eighth family had a member who was accepted on the waiting list for transfer to 2ECU from one of the hospital's acute care wards. Seven of the patients suffered from various forms of cancer; the remaining patient suffered from amyotrophic lateral sclerosis, a degenerative, neurological disease. As originally intended, follow-up was to occur with families before and after the death of the patient. However, for various practical reasons, made clear in the case reports, little follow-up occurred with families after the patient's death.

From the point of initial contracting with the hospital to the conclusion of casework, the study was conducted from September, 1979 to July, 1980. A tentative contract was struck with the Extended Care Unit Director in April, 1979. The contract did not involve the

hospital's Department of Social Work until September, 1979. The initial contact was made with the Unit Director as this social worker had been involved in a previous project under his management.

The terminal care program provides a truly comprehensive delivery of care to patients and their families. The goal of the program is to treat the whole person which involves the identification, assessment, treatment and evaluation of physical, psychological, social and economic needs. Out of necessity, as defined by these goals, the method of service delivery is a multi-disciplinary team approach. The team consists of physicians, nurses, physio and occupational therapists, pastoral care, social workers, dietetics, pharmacists, home care and hospital support staff. This social worker functioned as a member of the terminal care program team. The primary method of relating to the team was by attendance at the weekly case conference on 2ECU. At the case conference, information about the patient's progress/deterioration, care plan and social situation, was shared, discussed, evaluated. A planned total treatment approach was coordinated and formulated. The case conference was also the primary way this social worker was oriented to the philosophy and programs of the terminal care service.

The term social work approach to dying and bereavement, as used in this report, refers to a gestalt consisting of: dying and bereavement theory and intervention theory which coalesce into case specific interventive strategy. The available literature reviewed in this report was selectively exploited to develop a general conceptual framework which, in turn, was eclectically applied as the individual case demanded. The practicum contract in part defined the particular

interventive strategy and tactics used in each case. It had been agreed that this social worker would provide a comprehensive service and play a similar role to the permanent social worker on the ward. The agreement was based on an obvious need to be a clearly defined member of the team. Therefore, instead of purely being a specialist working with families experiencing difficulty with dying and bereavement, the role of general social worker had to be assumed as well. Thus, a host of activities undertaken came to be subsumed under intervention strategy and tactics. These included instrumental activities (i.e., referral to community programs, developing and engaging support systems, participating in the team) as well as contracting with family systems and individuals to provide supportive and adjustment counselling. Thereby, the goals of the practicum were:

1. to facilitate appropriate grieving in families by therapeutically using family process guided by an understanding of the issues inherent in dying and bereavement;
2. to support the adaptation of the dying and bereaved to their situation;
3. to maximize the self-help capacity of families coping with dying and bereavement;
4. to role model how the dying and bereaved can react to each other in family process;
5. to elicit feedback from clients, members of the 2ECU team and members of the practicum committee.

These goals are founded on a knowledge base which has led to the following assumptions about dying and bereavement:

1. The quality of grieving is limited because of our cultural and social death denial. However, the appropriate resolution of grief is dependent upon a sharing and open expression of emotion. Thus, families are placed in a double bind.

2. Not everyone requires professional help in coping with dying and bereavement.

3. An important task for professionals is to identify those families in need of counselling.

4. Engaging with families experiencing difficulty with dying and bereavement will be problematic; as the greater the difficulty experienced, the more the client system will isolate itself.

5. Owing to cultural and social prescriptions that dying and bereavement are essentially very private matters, the acceptance of counselling by the client system will be an ongoing and primary concern.

6. The terminal patient and their family cannot be dealt with in isolation from one another. Any change in one part of the client system will inevitably affect the entire system.

7. Families coping with dying and bereavement will benefit from ventilation of feelings and sharing feedback.

8. The social worker must be aware of his own feelings, values and attitudes towards dying and bereavement to maintain detriangulation and differentiation from the family emotional system.

9. To function in a multi-disciplinary team setting, the role and responsibilities of the social worker have to be clearly defined and understood.

II Practice Issues Raised in the Practicum

The operationalization of the aforementioned goals and the assumptions on which they are based, led to practice issues arising which affected the outcome of the practicum. From the beginning of this social worker's involvement at the hospital, the trust of the team was a major issue. This social worker was basically unknown to the team. Serious practical problems were anticipated if this social worker were only involved as a specialist in dying and bereavement. If ongoing social work responsibility remained with the ward's permanent social worker, how would the team differentiate and distinguish the two different roles? To avoid this foreseen role conflict, the only practical solution seemed to be for this social worker to function as a general social worker in the medical setting. Roles were then clearly specified. This social worker had total social work responsibility for certain patients. To be part of the team was necessary for supervision to be obtained from the team and the ward social worker. To become accepted as a member of the team was essential as staff members seemed to find communication easier and less inhibited once a familiar role was played by this social worker. Becoming part of the team's group identity also had positive benefits for the patient in terms of continuity of care. Generally, the purpose of social work intervention on 2ECU is to establish a therapeutic action system to support the patient and family and ease suffering. Congruent with this purpose, the overall goal of intervention is to help the terminally ill and their immediate family, deal with the problems of imminent death in their own way.

Role conflict was avoided in the context of the team but instead

was internalized by this social worker. Hospital expectations define the social worker's role in many ways to be a provider of practical help in dealing with instrumental issues. This social worker's basic purpose was to transcend this role by working with families experiencing difficulties with dying and bereavement. It was possible to engage families around instrumental issues to a greater or lesser degree, but it was very difficult to contract around difficulties with dying and bereavement. Instrumental problems are socially acceptable universal facts of life. Few people, on the other hand, admit to difficulties with dying and bereavement as social and cultural norms, values and beliefs about hiding and attenuating grief are then violated. Therefore, instead of being intensively involved providing counselling around family difficulties and experiences of dying and bereavement, much time was spent on instrumental issues. Sometimes dealing with instrumental issues provided an opportunity for assessment which revealed difficulties with dying and bereavement. However, it seemed inevitable that there would be severe difficulties changing the contract from addressing instrumental to relationship maintenance issues.

The nature of the referral process and the referrals themselves made to this social worker reflect role expectations of a general social worker in a medical setting. Generally, referrals were made to this social worker by a member of the team on the basis of perceived specific problems or problem behaviors. In other words, a symptom was identified which was equated with dying and bereavement difficulties and treatment was sought from this social worker. The nature of this referral process, however, meant that families were being referred without their request

or consent. Perceived needs were ascribed to the client system by a member of the team as opposed to a felt need being identified by the family. In other words, rather than a family presenting one of its members as the identified patient and asking for help in some way; a specific issue or problem behavior was presented by the team as an indicator of needed help. The nature of the referral process then stigmatized the family or one of its members as "in need of help."

The "problem" focus of the practicum seriously endangered the viability of the practicum itself. The practicum was tainted by a seeming search for pathology which could be addressed in family process and therapy. The self-help capacity of families was downgraded in this way contrary to the intent of the practicum. A way of liberating the dying and bereavement process from self-imposed restrictions and then stepping aside to let the process to happen naturally was not found. Moreover, the problem focus of the practicum led to many problems with contracting and relationship formation. To enter into a relationship of mutual trust with this social worker could have been interpreted by client systems as an indication that they had a problem. Most families when confronted in this way whether they are experiencing dying and bereavement or not, will, as a sign of health resist the degradation or labelling process involved in being singled out as "in need of help." One benefit of being cast in the role of the general social worker was that as relationship grows with the client system, a specific contract, dealing with specific family issues relating to dying and bereavement could be developed.

The referral process also illustrates the operation of the medical model. Assumptions were made by the referral source that certain

specific problems and problem behaviors were symptoms of difficulties with dying and bereavement. In effect, a diagnosis had been made and a treatment prescribed (i.e., referral to social work). The linear thinking of cause, effect, and treatment inherent in the medical model was also clearly in conflict with the circular, interactional, systemic conceptual framework which is the basis of this social worker's approach.

The reason for the referral always coloured this worker's response to the client system. If the client was referred for discharge planning or because of family conflict, inevitably, this social worker's initial activity was always oriented to that problem. This social worker was thoroughly inducted into the role of the hospital social worker. Reinforcing the induction was the expectation of recording on the patient's chart in the problem oriented medical record format. Thus, the shift from linear to circular thinking about the families was made more difficult. At times it was therefore very difficult to maintain a family approach rather than a medically oriented disease perspective. Process was frequently overlooked in favor of content.

The issue of responding to the reason for the referral also resulted frequently in this worker undertaking a flurry of activities on the client's behalf. It had become evident that helping with instrumental problems was a way of engaging the client system so that a possibility of establishing a contract existed. Thus, this social worker was frequently prone to the "I've got to do something" process trap (Kuypers and Trute, 1981) as shown in the case reports. The tendency to fall into this trap could also be a mark of this social worker's relative inexperience in working with the dying and bereaved. Accordingly, without being aware of the tendency, this worker may have

seemed over solicitous at times. This worker's need to do something may have produced unnecessary engagement problems and caused at least one hostile client reaction.

If this social worker had previous social work experience in a medical setting, the learning experience of the practicum could have been greatly enriched. Instead of focusing on dying and bereavement issues directly, time had to be spent orientating to the medical setting. It had been assumed that previous related experience obtained while conducting a research project on ZECU would suffice as an introduction to hospital social work. This was not the case. Hospital social work poses unique practice issues which must be addressed and reconciled for the social worker to be effective.

Friction arises between the disease-oriented model adhered to by the medical profession and the interactional, systemic and often ecological focus of social work. Frequently social workers are ascribed a role of providing nothing more than practical help for patients. Role confusion, questions of professional autonomy and the identity of social work are perennial issues to be confronted. Sometimes coprofessionals do not really regard social work as a profession at all. The question of who the client is must frequently be debated and justified. Other professions who adhere to the view that the needs of the patient are primary can automatically assume that the social worker's client similarly is the patient. Serious confusion and sometimes conflict can result as it becomes clear that the social worker's client is the family too. The conflict in the perception of who the client is, is perhaps clearest when the subject of discharge planning is raised. As hospital facilities are taxed to the limit by demands for needed medical care, hospital beds

can become a scarce material resource. Exacerbating this difficulty is current funding restraints as governments allocate financial resources to other priorities. Thus, there can be an emphasis in the hospital on "clearing the beds" for others. Sometimes among members of the medical profession, there may be a perceived lack of need for a patient to continue to occupy a much needed bed in hospital. However, if the family's emotional system and the proposed primary care-giver's capacity to care are limited because of relationship problems, discharge home may be impossible. Terminal disease poses particular problems in this regard. Pain control and other medical technologies may allow many discharge planning opportunities. Discharge home may not always be practical or feasible when the family is unable to cope with the demands of in-home patient care. In this regard, it is particularly important to draw assessment distinctions between inability to cope with patient care case demands and difficulty coping with dying and bereavement. This distinction may have occasionally been lost by this social worker in the casework process. When family needs and hospital needs "to clear the beds" conflict, it can become necessary for the social worker to advocate on the client's behalf. Opportunities to advocate for the client can also facilitate engagement and contracting on treatment issues.

Evaluation has proven to be a definite shortcoming of this practicum for a variety of reasons, partly practical and technical. Indirect measures of outcome such as projective tests were ruled out. In consultation with the practicum committee and collaterals at the hospital, it was decided that dying and bereavement impose enough on the client system without indirect measures of questionable value being

applied as well. A quasi-experimental design was impossible because of practical problems such as attrition, involved in setting up a control group and experimental group.

Direct measures of outcome seem to offer some potential evaluative tools in the study of treatment efficacy in dying and bereavement. A technique-oriented approach did not seem feasible, as it calls for a highly controlled outcome evaluation. All clients have to be treated in the same manner with the same single technique. However, the problems people encounter with dying and bereavement are too varied, individualized, and complex for a single treatment approach to be appropriate for all clients. Different people respond to imminent loss in different ways and have different needs. As such, the treatment offered in intervention cannot be standardized for all clients. For some client systems, a supportive approach may be all that is necessary to relieve a burden of self-doubt from a difficult process. Other situations may require a more directive approach such as crisis intervention or an induced, planned change model.

A number of considerations would apply if evaluative research on this social worker's approach was to be undertaken in the future. The 2ECU setting already has its own treatment package in its multidisciplinary, problem-oriented team approach. Therefore, it would seem that the evaluation strategy most applicable to the setting is a construct strategy. The existing treatment package at 2ECU could be augmented by the treatment package provided by the researcher. The construct strategy would have to be based on a single case design

using process and direct measures of outcome evaluation. The direct measures would probably include client self-report and direct observation of behavior.

Rigorous evaluation of intervention was not pursued in this practicum as that task seemed to be so involved, in and of itself, as to be the subject of a thesis or practicum in its own right.

III Themes and Issues Raised by the Case Reports

The study of the cases suggests certain themes and issues are prominent which have been already presented in the literature review.

Denial is a first line of defence as socialization and "face-work" expectations effectively sanction denial. Pervasive denial may frequently be a mechanism used in families to cope with successive emotional shockwaves of dying and bereavement. Without the pervasive denial, fear of death and mortality would be so strong as to paralyze normal activities and relationships. The effect of pervasive denial cannot be held at bay. While relationships may continue, it is inevitable that relationship rules are built to reinforce the denial. The relationship rule may affect the quality of all relationships and communication patterns in the family. However, if death has a place in life then the reality base of life itself is eroded by family mystification. Existential denial then becomes an existential vacuum filled with self-alienating anxiety.

Death offers a new opportunity for an existential choice of how one will live life. Once the confrontation with personal death becomes so apparent that denial can no longer be effective, the

ultimate and final choice in life becomes clear. Death can be a painful, self-alienating, degrading experience or it may change life orientation totally. Instead of living as if death can be postponed and further reprieves obtained, immediacy of experience and awareness of life's endless choices can govern consciousness. Death can be "an adviser" (Castaneda, 1975) A new sense of choice, responsibility and control can emerge such that pain and death, in a sense, cease to exist. Fear no longer would rule life.

Emotional shockwaves can leave an imprint in relationship rules that attempt to ward off losses and disappointments. The relationship rule protects the family from confronting their unfinished business but also prevents congruent responses to other family situations. Instead the unfinished business dictates a reaction that reflects the fusion of the family emotional system and a sense of learned helplessness.

In families with unfinished business, it is almost as if they could be heard saying: "I know I shouldn't be (feel) this way but I can't help it. It hurts so much." Family situations of change that imply loss or disappointment may reawaken feelings of loss and pain from unresolved grief. There may seem to be a feeling that nothing can change. The family feels doomed to repeat the past.

Closed communication systems in families reflexively close further to avoid sensitive subjects such as dying and bereavement. The fusion of emotional and intellectual functioning enables family functioning to continue as it has without question or doubt. The mystification process creates an illusion of safety. Such families may scapegoat one of its members so that he becomes the focus of the tension and strain generated by the closure of communication in the

mourning process. Families maintaining a stoic response or "a secret" while confronting dying and bereavement are other examples of closed communication systems.

The case studies demonstrate that families experiencing dying and bereavement can frequently find themselves in a double bind. The literature review suggests that it can be inferred that every family, to a greater or lesser degree, is subject to a double bind. Cultural and societal prescriptions dictate that dying and bereavement are private matters to be dealt with in isolation. However, grief must be expressed openly and shared for family resources to be creatively utilized to bind the wound. Families may agonize not only about death and bereavement; but also may struggle with uncertainty of how to react. The answer to the double bind seems to be within the family itself. If families adaptively coping with dying and bereavement are to be able to choose alternative ways of dealing with their situation, then they must accept responsibility for how members of the family cope with the process.

The sick role is a collaborative, reciprocal function performed by the patient to secure exemption from responsibilities and elicit a helpful, solicitous reaction from social systems. The sick role helps to normalize the relationships of the patient with a serious illness. Thus, the patient remains socially alive and the illusion of death denial is maintained. The expectation is created that the illness is only of a temporary nature. When recovery does not occur within the temporal limitations of the sick role, patients may have difficulty surrendering to the psychological regression inherent in dying. The perceived difficulty "letting go" can create a sense of guilt in the

family. Family members feel helpless to deal with the patient's evident physical and psychological torment. Reacting to the failure of recovery to occur, the family may question medical decisions to cease active treatment and/or become even more solicitous towards the patient. The ambivalent struggle in the sick role "to keep or let go" seems to parallel Erikson's second stage in personality development--autonomy vs. shame and doubt. If autonomy develops separation will ease into being. If shame and doubt arise, protest will characterize the process such that a serious grief reaction may result.

IV A Reexamination of the Literature

Comment has been made previously on the overwhelming intrapsychic bias of the literature. The social work approach to dying and bereavement suggested here draws partly on the intrapsychic literature as it seems clear that individuals and families experience the same process.

The primary literature resources used to develop the conceptual framework here are to be found in existentialism, life cycle theory, crisis theory and interactional-systems theory. The weak link in the approach is probably the use of interactional-systems theory. Using a systems perspective results in a shift in thinking from the linearity of the medical model to the circularity of an interactional model. The shift is not easy. Some writers struggle to push their approach and thinking but never quite meet the challenge. Kubler-Ross for instance, while working with families still seems to treat them as individuals, using the family as if it were a backdrop. She seems to avoid assessing and using active interaction among family members to bring about change in adaptation to dying and bereavement.

That this writer's greatest debt is owed to Murray Bowen is

probably no accident. From this writer's knowledge of the body of family literature, Bowen is the only family theorist to attempt to apply his approach to dying and bereavement. Any weaknesses in the approach or its application, as suggested here, however, are attributable only to this writer.

Appendix--Case Reports

I. Mrs. A.

Mrs. A. was referred in January, 1980 by a social worker supervisor as a case that could be transferred from the part-time ward social worker. Mrs. A's daughters, Mrs. M. and Mrs. B. had considered taking turns caring for their mother in their homes when discharge was possible from an acute care ward of the hospital. However, before definite discharge plans were made, both daughters requested more information on the care involved. As the ward social worker had not met with anyone in the family, the transfer to this social worker was initiated for appropriate discharge planning to occur.

Mrs. A. had lived in a small town in rural Manitoba. Her diagnosis was cancer of the bladder. Mrs. A.'s husband had died a few years earlier of a brain tumor. Mrs. A. had three adult, married daughters living in various rural locations in Manitoba. For this study they are labelled Mrs. M, Mrs. B, and Mrs. C.

Mrs. A. had been living in senior citizen's housing and had lived independently until December, 1979. At that time she became weak, had no appetite, had difficulty walking and seemed confused at times. As Mrs. A. could no longer function independently, she moved into the home of one of her daughters, Mrs. M. She stayed Mrs. M.'s home for approximately one month before she was admitted to an acute ward of the hospital January 9, 1980. By the end of January she had become more confused, weaker and was unable to walk on her own.

This social worker's role had been defined by hospital expectations as a facilitator of discharge planning and to provide supportive counselling.

To meet the request of Mrs. M. and Mrs. B. for more information regarding the care that would be involved in Mrs. A.'s discharge home, a family conference was organized by the Home Care Department. Time did not permit this worker to meet Mrs. A. before the scheduled family conference to determine what her wishes were. Attending the family conference were the home care nurse, Mrs. M., Mrs. B., Mrs. C., and this social worker. Public health and V.O.N. assistance were offered in managing Mrs. A.'s home care. The family declined the opportunity to take Mrs. A. home. They seemed to arrive at this decision very quickly as if the decision had been made amongst themselves before the family conference.

Work activity from that point became weekly visits with Mrs. A. The goal was to provide a source of support for Mrs. A. and her family. The first time this worker met Mrs. A., she expressed a desire for euthanasia. When this worker acknowledged Mrs. A.'s wish to die, her only response was to look away. During subsequent visits Mrs. A. responded verbally only to acknowledge this worker's visit. Then she ceased responding verbally altogether. This social worker identified himself on each visit. The purpose of these visits was identified as: "coming to see how you are." The visits usually lasted about fifteen minutes and were spent in silence.

During one of these weekly visits in April, 1980, Mrs. A.'s condition seemed to have deteriorated. She was lying in a fetal position, sleeping and her face seemed very drawn. Mrs. B. was present

at the time of this social worker's visit. She was distressed about the change in her mother's condition with regard to swelling in her feet, and was concerned about what medication her mother was receiving and who the doctor was. Mrs. B. was advised of who the attending physician was. Mrs. B. also indicated that the family is uncertain about what is happening with Mrs. A. Mrs. B. was advised that her mother was on a waiting list for transfer to 2ECU, the terminal care unit. The possibility of a family conference with Mrs. A.'s physician was suggested. Mrs. B. responded positively to the idea of a family conference. Organizing the family conference was discussed with the head nurse. She offered to organize the conference with the doctor giving the family one day's notice because of the travelling involved. A few days later the head nurse advised that a family conference could not be set up as the physician failed to see the need for one. Mrs. M. was visiting her mother on that day and stated that she could see no reason for a family conference. Mrs. M. maintained that in the past she had handled the responsibility of family spokesperson and felt that she could obtain whatever information needed for the family by calling the doctor. She said she would check this out with her sisters. Mrs. M. was contacted the next day and reported that her sisters had agreed that she could just phone the doctor for them. I advised the head nurse of the family's decision to simply call the doctor. Mrs. B. was not contacted directly by this worker as her phone number was unavailable and the exact location of her residence in rural Manitoba was not known. Two days later, Mrs. M. was seen at the hospital during this worker's weekly visit with Mrs. A. Mrs. M. advised that her sister Mrs. C. was to be

admitted to hospital for some minor surgery.

On April 15, 1980 Mrs. A. died. In calling Mrs. M. to express condolences, Mrs. M. said that Mrs. C. was in hospital and had just had surgery. Mrs. C. was visited in her hospital room a few hours after she had left the recovery room. She seemed to be in no discomfort and was aware of her mother's death. Mrs. C. reported that she had had a mastectomy in November, 1979 during which both breasts were removed. Then in January, 1980 Mrs. C. had silicone implants placed and there supposedly had been some minor complication. Mrs. C. however, indicated that she had not had cancer, and had the mastectomy only because the doctor had told her it would prevent the future development of cancer.

Further contact with this family did not take place. Mrs. M. was made aware of this worker's continued availability when condolences were expressed.

Case Commentary--Themes and Issues

Mrs. A.'s expression of her death wish could have been associated with her knowledge of the fact that her daughters would not be taking her home. Possibly Mrs. A. wanted to spend the remainder of her living/dying process with her family about her in the secure familiar environment of their homes. Perhaps she interpreted her daughters' unwillingness to take her home as a rejection and a separation for which she was not prepared. Her confusion could have been the result of institutionalization and the progression of her disease. Mrs. A. became sleepy and withdrawn in preparation for death. She seemed detached from her surroundings and acknowledged visitors reluctantly.

Mrs. B. seemed unaware that her mother's sleepiness and withdrawal were natural components of the dying process and an indication of decathexis. Mrs. B. seemed to fear this regression.

A fundamental issue demonstrated in this case is the role conflict of this social worker. Hospital expectations predefined this social worker's role as facilitator and planner of discharge arrangements. Instead this worker's purpose was to work with families experiencing difficulties with dying and bereavement. Therefore the contract offered this family was a dual one. The former they may have been willing to consider for a brief time but the latter never became part of their agenda. Therefore, when discharge planning was rejected by the family, this worker attempted to continue an involvement for which there was no contract. A contract may have been possible, but the data needed to work out the contract was not presented by the family in the initial stages of involvement.

This family's refusal to accept Mrs. A.'s discharge may have been an expression of their inability to cope with the successive emotional shock waves of dying and bereavement.

This family clearly demonstrates secrecy as a way of maintaining a pervasive system of denial which in turn acts as a shield from the pain of confronting death. Mr. A. had died slowly and painfully from a brain tumor a few years before. Then Mrs. A. developed cancer. Mrs. B. and Mrs. M. subjectively reported they expected their mother's death to be easier for them than their father's death. Mrs. C. remained silent on this point as her own fears of her disease made it very difficult to cope with her mother's death and dying. Before Mrs. A.'s death, Mrs. M. reported that Mrs. C. was to be admitted for some minor

surgery. On the day of Mrs. A.'s death, Mrs. M. informed that her sister was in hospital too and had just had surgery. When Mrs. C. was visited in her hospital room only then did she report having had a mastectomy in November, 1979. She denied that she had had cancer and maintained that her current hospitalization was to correct some minor complication arising from the placement of silicone implants. Mrs. C. maintained that she had undergone the radical mastectomy because her doctor had advised that the removal of her breasts would prevent the future development of cancer. Mrs. C.'s denial was not challenged as that would have been both unappropriate and unethical. There was no relationship or contract with Mrs. C. The emotional shock waves of serious illness had produced a reflexive system of denial to "ward off" potential and current losses. The conspiracy of silence involving Mrs. C.'s disease may have been an indication of a defensive family mystification process in action.

The relationship rule which lead to the family selection of Mrs. M. as their spokesperson seemed to help maintain the denial system and the closed style of communication. From Mrs. B.'s request for information regarding her mother's medication, deterioration, de cathexis and the doctor's identity, it seemed that there was no substantive sharing of information occurring. The doctor's refusal to attend a family conference as requested by Mrs. B. helped maintain the closed system of communication. Therefore, the doctor's failure to see the need for a family conference and the family's refusal to accept Mrs. A. home were both attempts to prevent contaminating the family system with a reminder of the fact that cancer seemed to be occurring with a high frequency in this family. The identification

of Mrs. C.'s disease and its effects on the family as a target system was thwarted until the contractual link with the family--Mrs. A. had literally died.

II. Mr. B.

A few days after his admission to 2ECU, Mr. B. was referred by the ward social worker. The reason for the referral was that Mr. B.'s affairs were not in order. It seemed that Mr. B. would have to give up his apartment in senior citizen's housing as he was unable to function independently although Home Care supports were provided. His diagnosis was cancer of the prostate.

Mr. B. was in his seventies. He had never been married, had no children and initially maintained that he had no family. His neighbour in senior citizen's housing, Mrs. J. had been paying his bills for some time prior to Mr. B.'s admission. Mrs. J. felt that responsibility for Mr. B.'s affairs was not properly her's. She also found the responsibility burdensome because of her ill health. On admission to hospital, Mr. B. was socially outgoing with fellow patients, staff and visitors to the ward. Then shortly after his admission, Mr. B. became somewhat confused, withdrawn and for all intents and purposes confined himself to his bed.

Initially, this worker's role and activities revolved around attempting to work out some arrangements that would settle Mr. B.'s affairs. Mr. B. talked about having "friends" at the Legion and Union Centre with whom he drank. None of these acquaintances came to visit him in hospital and therefore seemed unlikely support systems for him. From Mr. B.'s hospital admission, it was learned that

Mr. B. had named a cousin, Mr. H. as his next of kin. Mrs. H. resided in a rural Manitoba town. When asked about Mrs. H., Mr. B. responded that he had not seen her in years and was uncertain if she would wish to have anything further to do with him. It was pointed out to Mr. B. that he needed someone to look after his affairs as the responsibility was too great for Mrs. J. Mr. B. agreed that Mrs. H. could be contacted by this worker. Mrs. H. responded very positively to telephone contact by this worker. Mrs. H. was planning to come to Winnipeg and she agreed to see Mr. B.

During the subsequent visit, Mrs. H. and Mr. B. shared reminiscences. They discussed how their lives had intersected and engaged in a mutual life review process. Mrs. H. presented as a very warm, compassionate and caring person who conveyed her attitude freely and clearly to Mr. B. Mr. B. seemed to take particular delight in discussing particular incidents from when he was still residing in the rural town where Mrs. H. still resided. Mrs. H.'s positive recollections of Mr. B. in his youth seemed to give him a more positive perspective on his life and a sense of having fully lived.

At this worker's suggestion, Mr. B.'s financial affairs were put in order, arrangements were made for the relinquishment of suite and the storage of belongings. Mr. B.'s prognosis was discussed and funeral plans were made. Further visits by Mrs. H. seemed to reassure Mr. B. that he would not be forgotten and abandoned again.

For a period of one month this worker's contact with Mr. B. was twice per week for varying periods of time. Thereafter, following Mrs. H.'s visit there seemed to be no definite role for this worker. During the last three months of Mr. B.'s life, contact occurred about

once per week. These visits were primarily of a social nature as Mr. B. had definitely made the ward his new home and he became very comfortable.

Case Commentary--Themes and Issues

Mr. B.'s initial withdrawal, confusion and confinement to bed after his admission seemed to be the result of his denial suddenly becoming ineffective when he realized he would not be returning home. Depression then set in which was unrelated to any physical deterioration on his health. It seemed that as a result of Mrs. H.'s visit, Mr. B.'s spirits improved and his depression was replaced with a desire for joy and fun during his last days of life. Mr. B. developed numerous relationships with staff and he became close to his roommate. Mr. B. became a familiar sight going up and down the hall in his wheelchair. He impressed staff and fellow patients with his sense of humour and simple forthright personality. He became recognized as a semi-official ward welcomer who greeted visitors and hospital staff entering the ward.

The involvement with Mr. B. presented an unique opportunity for hospital expectations to coalesce with this worker's intention of working with families experiencing difficulties with dying and bereavement. Rather than simply becoming involved in a practical sense to help sort out Mr. B.'s affairs; this social worker attempted successfully to reconnect him with what remained of his family network. When Mr. B. denied having any relatives, he seemed to be symbolically expressing his fear of being a burden. Like a catalyst Mrs. J. presented Mr. B. with the opportunity to make an existential

choice. He could continue to die unhappily and alone or he could choose to live so that every moment counted. His choice was the latter. He found new meaning in life. His sense of humour and sociable nature glowed brightly if only for a few months. This change in Mr. B. reverberated throughout the social system of the ward. He joked with everyone. To learn that others--even a cousin he had not seen for many years--could see him as worthwhile and desiring respect must have been very gratifying for Mr. B.

III. Mr. C.

Mr. C. was referred to this worker in January 1980 by the Home Care Department. The Home Care Department was concerned because Mr. C. had recently been assaulted by his daughter. He had also indicated to the visiting V.O.N. that he was having financial difficulties.

The client system consisted of approximately seventy year old Mr. C. and Mrs. S., his approximately forty-five year old daughter. Mr. C. was a widower, his wife having died of leukemia in September 1979. Mrs. S. was divorced from her husband. She lived alone and was unemployed. Mr. C. was unsophisticated in his demeanor and interaction. He was alert and oriented. Mr. C. described his daughter as having a serious drinking problem.

The C family had operated a small farm in the rural Winnipeg area. Mr. C. also worked many years for the Canadian Pacific Railway. Mr. and Mrs. C. had two children--a boy and a girl. The son died during World War II of leukemia shortly after being conscripted. Mr. C. was of Ukrainian origin and was raised as a Roman Catholic. Subsequently, he became a Jehovah's Witness but did not practice any

religious affiliation. Mr. C. had a brother and two nephews in the city with whom he had not maintained any contact.

The problem which this worker sought to address was the conflict between Mr. C. and Mrs. S. The outstanding issues between them seemed to require intervention if they were to deal with unfinished business. Secondary to the concern seemed to be how Mr. C. was coping with his living/dying process. Intellectually he was aware of his diagnosis and prognosis. Initially, he seemed to minimize the consequences of his disease. Mr. C. matter of factly acknowledged his dying when this social worker conveyed permission for Mr. C. to discuss his dying openly. He lived an unnecessarily austere life-style. Mr. C. had over \$20,000 in cash assets but he denied himself even small luxuries in terms of basic foods. This pattern of self-denial seemed consistent with his previous life-style. However, there seemed to be a symbolic element of death denial present as if he expected life to go on definitely.

The issues between Mr. C. and his daughter which lead up to the assault essentially remained undefined. When interviewed, Mrs. S. presented as an angry, belligerent lady obsessed with hatred for her father. Mrs. S. blamed her father for her mother's death because of his "meanness." She complained about Mr. C.'s irritability and the unnecessarily austere life-style she believed he had imposed on her mother. Mrs. S. attributed her mother's rapid demise to her father's selfish mentality. During the early morning interview with Mrs. S., she was obviously under the influence of alcohol and she admitted having been drinking. In the late fall of 1979, Mrs. S. received a gift of \$70,000 from her father. Mrs. S. persuaded her father to give her the

money while he was alive rather than after his death. Mr. C. agreed to do so on the condition that she use these resources in part to provide for his needs. When Mrs. S. did not perform her part of the contract, Mr. C. confronted his daughter and an argument ensued. Mr. C. alleged Mrs. S. hit him repeatedly with his cane, knocked him down and continued hitting him. Mr. C. was treated in hospital for a cut to the scalp and broken ribs. Mr. C. had complained to the police but decided against making an official complaint. Mr. C. ruled out seeing a lawyer to determine if he would be able to recover his \$70,000. Following the incident, Mr. C. changed the locks on his doors and obtained an unlisted phone number to control who had access to his suite and person. There was no direct contact with her father except sending a Father's Day card and an ensuing telephone call initiated by Mr. C. Mr. C. seemed to live in fear of his daughter coming back to see him only to give him another beating. As a result of his fears and sense of loss, Mr. C. demonstrated an exaggerated need for financial security and total lack of trust in Mrs. S.

When Mrs. S. indicated no interest in meeting with her father and Mr. C. was reluctant to meet for fear of his safety, a contract to address their conflict was impossible. From that point, once every two weeks for one to two hours per session for a period of five months, this social worker met individually with Mr. C. The initial contract with Mr. C. was to provide supportive counselling. As the relationship developed, the contract expanded to address his unfinished business and adjustment to dying. Attempting to work through these issues created a dependent relationship. As difficulty with termination was anticipated, the services of a volunteer were obtained to provide at

least friendly visits for Mr. C. Mr. C. refused to consider any attempt to involve his brother and nephews as a potential source of support. During the termination interview, Mr. C. begged this worker to continue seeing him and offered to pay for ongoing involvement. As tears came to his eyes, Mr. C. suppressed them and became very quiet and withdrawn at the end of the interview.

Case Commentary--Themes and Issues

The role of unfinished business dominated Mr. C. and seemed to similarly affect his daughter. Mr. C. would not discuss his wife's death despite being offered many opportunities to do so. Following this loss, Mr. C. also lost his daughter through what he saw as her betrayal. His response to the emotional shock waves of these losses was to turn inward on himself. He became depressed. In despair, he saw his disease as another insult which he was powerless to control. Rather than deal with his despair, Mr. C. chose to resist involvement with family which could have met his need for love and intimacy. He may have feared his daughter's wrath because he felt responsible for his wife's demise. With the death of his wife, a well of unfinished business concerning the death of the son may have been tapped for Mr. C. The symbolic connection may have been very strong as both son and mother had died with leukemia. Mrs. S. may then also have held her father responsible for the death of her brother and mother. These deaths may have required Mrs. S. to direct all her emotional energy towards self-control. The net result was an emotional protest of these losses demonstrated in hostility. Mrs. S.'s hostile, learned response to bereavement may have confirmed for Mr. C. that he was wretched, worthless and his life had been meaningless. Owing to this

existential anxiety, Mr. C. saw himself without any intrinsic dignity and unworthy of respect, caring and love. Thus he felt he had no choice but to try to buy his daughter's love and solicitation. Death would cease to exist for Mr. C. if he had his daughter's love. That was not to be, Mrs. S.'s unfinished business was overwhelming.

Mr. C. talked about feeling as if he did not belong in a world stressing the values of youth, progress and competition. He viewed society as out of step with human nature. By addressing the question of meaning on a macrolevel, Mr. C. may have symbolically been attempting to deal with his unfinished business regarding his daughter. As if he was wondering aloud, he spoke often of not understanding his daughter. Mr. C. regarded his life as a source of sorrow. He was isolated and alone. He felt he had too little time left as life was being taken from him. Therefore, because he had no time left or because he wanted the easy way out, Mr. C. sought to buy this social worker's continued involvement. He was desperately trying to fill the existential vacuum in his life.

IV. Mrs. D.

Mrs. D. was referred in April 1980 by the Home Care Department of St. Boniface General Hospital. Home Care initiated the referral because concern had been expressed by Mrs. D.'s daughter, Mrs. H, for the ability of Mrs. D.'s son Mark, age 24 and mother, Mrs. F, age 73, to adjust and cope with Mrs. D.'s disease.

Mrs. D. had cancer of the head of the pancreas with a poor prognosis. Mrs. F. had been blind for most of her adult life. Mrs. F. was found to have cancer of the throat in 1977. She had been

treated with surgery and radiation. Mrs. F.'s disease had since been in remission. A biopsy taken in June 1980 from ulcers in Mrs. F.'s mouth did not show a return of her disease. Mrs. H. was a nurse employed in a Winnipeg Hospital and had been recently married. Mrs. H. was Mark's half-sister.

Mark had dropped out of high school in grade 10 and joined the U.S. Army when he was 17. When discharged, Mark returned to Winnipeg, enrolled in a course at Red River Community College and dropped out. He obtained employment and quit after two years. Mark had been unemployed since January 1980. He devoted most of his time to watching television, and pursuing his interest in hang-gliding, audio equipment and sports.

Mrs. F. had been married twice. Mrs. D. was the only child from the first marriage. Mrs. F. had no other children. It was during the second marriage, when Mrs. D. was 13, that her mother developed blindness. The stepfather blamed the then adolescent Mrs. D. for his wife's blindness. Mrs. F.'s second husband died of a heart attack.

Mrs. D. left home when she was 17 and married for the first time when she was 19. From this marriage she bore two children, Mrs. Y., who resided in Reno, Nevada. Mrs. H., Mrs. D.'s first marriage ended in divorce when she discovered that her husband "constantly misled" her. Mrs. D. was reluctant to discuss what "constantly misled" meant. Mrs. D. then married Mark's father who was an American. This marriage also ended in divorce for a reason Mrs. D. would not discuss. Until her disease imposed physical limitations, Mrs. D. had been employed for years as a drugstore clerk.

Worker activity began with attempting to engage the family by

organizing a family meeting. The goal was to attempt to work with the family to facilitate adaptation to dying and bereavement. The adaptational tasks would be addressed by bringing about appropriate change in family relationship patterns that may have been contributing to difficulty with dying and bereavement. During the meeting a contract was developed dealing with providing support around instrumental issues. A subsequent meeting with the family was not seen as necessary by Mrs. D. Instead she suggested telephone contact would suffice regarding the instrumental issues. Mrs. D. also suggested that this social worker could possibly meet with Mark. He remarked that he would appreciate discussing the problem of his mother's disease further. It seemed that in presenting Mark as an identified patient, the family was presenting itself as "in need of help" without stigmatizing themselves. In so doing, direct admission of difficulty with dying and bereavement was avoided. The family seemed to be attempting to normalize, in relatively more acceptable terms, the degradation process involved in voluntarily engaging with a social worker. Perhaps it was even more important for the family to engage in the scapegoating process as they were becoming involved with a social worker whose stated purpose was "to work with families who may be experiencing difficulties with dying and bereavement."

The subsequent meeting with Mark provided him the opportunity to ventilate considerable hostility for his sister, Mrs. H. This stemmed from Mrs. H.'s method of informing Mark about Mrs. F.'s disease three years ago. Mrs. H. supposedly bluntly told Mark over the phone "Grandma is going to die." This was very upsetting for Mark because this information-giving proved to be premature given the remission of

Mrs. F.'s disease. Mark generalized his feeling of hostility and spoke of "feeling like I'm going to explode." Mark talked about feeling depressed and his interest in hang-gliding in terms which suggested a strong death wish.

Prior to meeting with Mark, Mrs. H. had contacted the 2ECU social worker and expressed concern for Mark's lack of direction. She had also reportedly commented that she had left home at 19, because she "couldn't stand what was going on any more." At about the same time, Mrs. D. requested the discontinuance of homemaking and V.O.N. service as the family seemed to feel that these services were more of an intrusion than a help. The next goal seemed to be to arrange a family meeting including Mrs. H. Mark was only the symptom-carrier in the family. Therefore a family meeting seemed necessary to redefine and reframe "the problem" in terms of the family by taking the focus off Mark. The secretive quality of this family and the behind the scenes manipulation by Mrs. H. also indicated that calling together of family resources was required for therapy to progress. The plan to approach Mrs. D. about a family meeting was delayed by the deterioration of her condition necessitating admission to hospital for stabilization of nausea and vomiting.

Owing to this delay, in supervision it was decided that termination should occur as this social worker's period of availability for involvement was coming to a close. The family would then be followed by the 2ECU social worker. Possible referral of Mark to ambulatory psychiatric care was also considered a possibility. Individual termination interviews were set up with both Mark and Mrs. D.

During Mark's termination interview, he described having anxiety

attacks and feelings of hostility and aggression. He mentioned not knowing how he should be reacting and used the label "manic-depressive" to describe himself. Mark had earlier considered seeing a psychiatrist "because I can't feel." The topic of suicide was pursued by this worker because of Mark's depression and the wide contradictions in what he was saying. Mark maintained that he had not seriously thought of suicide and did not articulate any particular plan. Given the serious nature of these concerns, Mark was referred to ambulatory psychiatric care.

The termination interview with Mrs. D. was held shortly after her discharge from hospital. Mrs. D. could have remained in hospital had she chosen to do so. Instead she had opted for discharge and was elated to be home again. Therefore, the tone of this interview was basically one of a restrained sense of happiness.

Case Commentary--Themes and Issues

This social worker concluded that a family secret was being maintained. Mrs. E. had referred to "what was going on." Mrs. D. refused to have her daughter, Mrs. H. present for the family meeting. Mrs. D. would not discuss the break-up of both her marriages except in very broad generalities. During the initial family meeting, both Mrs. D. and Mrs. F. also identified conflict between them as an issue. Then as Mrs. D. and Mrs. F. repeatedly attempted to downplay their "conflict" and smiled at each other, it seemed that they were not prepared to deal substantively with whatever the issues were in their relationship. The reluctance of this family to engage as a family, possibly because of their "secret" illustrates a difficulty

inherent in a family approach to dying and bereavement. Taking the foregoing into account, the nature of Mrs. D.'s and Mrs. F.'s cancers and the suspicion of the Home Care nurse, it is conceivable that Mrs. D. and Mrs. F. may have drunk considerably. If drinking to excess was a reality, Mark's lack of direction could be understood in terms of difficulty finding a sense of meaning and belonging in life. It could be that the only role Mark saw for himself was as "protector" for his mother and grandmother given their inability to positively engage life. Mark's apparent apathy, as it was seen by his mother and grandmother, was then their own creation as it served their need. They had defined Mark in relating to him and created an enmeshed, emotional triangle. Mark's self-described feelings of hostility and aggression can then be seen not as pathology but as a normal, developmental tension arising from a delay in his individual life cycle task of emancipation, separation and individuation.

Providing the whole family with a choice of direction seemed to require involving Mrs. H. She was obviously a very powerful member of the family who caused things to happen when she "pulled strings" behind the scenes. The problem was how to engage her. Mrs. D. had refused to allow this social worker to invite Mrs. H. to the family meeting. Mrs. H. was known to the hospital only by her first name. There was no known home address or phone number. Therefore, the only conceivable way of approaching her seemed to be to contact the hospital where she was employed. From a number of ethical perspectives, however, taking the initiative to contact her would have been violation of confidentiality and privacy.

The nature of Mark's problem as identified by his mother suggests

he was caught in a double bind. At one level they were saying to him, "You are a problem, Mark. You have no direction, you must grow up." However, the actions of mother and grandmother towards Mark served to maintain him in a dependent family role within the household. Their messages implied we need you here to refocus our problem so that we do not have to confront our dying (and probably our drinking). The reason for the mystification, whether it was to maintain the family secret of drinking or to support a system of death denial is obviously speculative. The process and its impact on Mark is what is significant.

Mark's statements of not knowing how to react and his thinking of seeing a psychiatrist "because I can't feel" seem to be self-contradictory, confusing and mystifying. These statements contain statements about statements which are clearly contradictory. One cannot know that it is impossible to feel without feeling. The paradox involved suggests that Mark may have been in a double bind. Mark was closely emotionally attached to his grandmother and his older sister had told him rather bluntly in a telephone conversation "Grandma is going to die." Not only was this information-giving very premature but also, in hindsight, very inaccurate. Grandma failed to die. This could have been particularly confounding because he was told by his sister, presumably an authoritative source given her association with the medical profession. The way Mark described being told by his sister also implied to him that his grandmother's death was imminent. Anticipatory grief may have begun (for Mark) a process of emotional decathexis which he could neither undo nor complete.

V. Mr. E.

Mr. E. was referred in January, 1980 by the ward social worker following a 2ECU case conference. The Home Care Department assessment aroused concerns regarding Mr. E.'s daughter, Mrs. L. She had been financially dependent on Mr. E. and she was possibly alcoholic.

Mr. E. was seventy years of age and died just over a month after admission. Mr. E.'s diagnosis was a malignant, brain tumor. He was a retired sheet metal worker having been employed by Air Canada for almost thirty-five years. Mrs. E. had died approximately three months earlier of lung cancer. Mr. and Mrs. E. had been married for fifty years.

The first priority for this social worker's activity was to meet Mr. E. gather family information and begin a contracting process with the family. Mr. E. was lucid on admission and expressed himself well. He understood his admission to hospital to be for pain control and because of general difficulty managing at home. Mr. E. described his family in cooperative and supportive terms and stated that his affairs were in order. Despite his apparent lucidity, Mr. E. maintained that he did not know what his diagnosis was and spoke with a seeming lack of awareness of his physical condition and present, physical functioning. Mr. E. was very pleasant and agreed to a further meeting with this social worker.

Before another meeting took place, Mr. E. developed hallucinations and became confused on pain control medication. Mr. E. also developed spinal cord compression resulting in paraplegia while in hospital.

Concern developed regarding how the family may be coping with Mr. E.'s illness as it so closely followed Mrs. E.'s death. During a weekly case conference it was noted that Mr. E. had also not had any visitors. It was unknown if any alternative arrangements had been made for Mrs. L.'s financial support. For these reasons, Mrs. L.'s reaction to her father's impending death was a major concern. Therefore an attempt was made to organize a family conference to share information with the family, allow assessment to occur and facilitate contracting as appropriate. Mr. E.'s son Leonard was contacted regarding any concerns the family may have had that should be dealt with by means of information-sharing in a family conference. Leonard indicated the family understood Mr. E. to be terminal and that everything that could be done had been done and everything was being done that needed to be done. Leonard stated that the family had made arrangements to provide for Mr. E.'s daughter, Mrs. L. Leonard felt that there was no need for a family conference as the family understood and appreciated the situation.

An effort was made to engage Mrs. L. to offer the opportunity to raise any concerns she may have. However in response to a phone message left for Mrs. L., her son (Mr. E.'s grandson) returned the phone call. Mr. L. wondered why an attempt had been made to contact his mother. It was explained that the attempt had been made to contact Mrs. L. to answer any questions that she may have about Mr. E.'s condition and to offer the opportunity to raise any concerns. Mr. L. related that the family had decided that his mother must be protected from knowing the facts of Mr. E.'s condition. Mr. L. reported the family as a whole was aware of the nature of Mr. E.'s condition but

they had only told Mrs. L. that Mr. E. was "doing all right." Mr. L. indicated that he felt his mother would "take it pretty hard" when her father, Mr. E. dies. Mr. L. mentioned that this was particularly going to be the case as Mrs. E., the wife of the patient and Mrs. L.'s mother, had died recently of lung cancer. Mr. L. felt that nothing could be done to make it easier for his mother when Mr. E. dies. Mr. L. said that he would contact this social worker if he should feel that his mother would benefit from contact. Mr. L. related that he had no concerns about his grandfather's condition. Shortly afterwards, Mr. L. came to visit his grandfather briefly. He was Mr. E.'s only visitor.

When Mr. E. died, the family was notified by nursing staff but none came to view the body which was regarded as unusual by the staff. The only exception was Mr. E.'s brother who happened to come on the ward to visit his brother not knowing he had died. The brother's reaction was very controlled and there was no overt display of emotion or grief. In spite of finding out that Mr. E. had just died, his brother denied that he was shocked by the news. This worker sat with Mr. E.'s brother for some time to give him the opportunity to discuss his feelings or ventilate. Instead the brother remained rather stoic, withdrawn and quiet.

Case Commentary--Themes and Issues

The difficulties inherent in the family approach are exemplified by Mr. E. and his family. How do you engage the family system when the patient absolutely denies knowledge of his diagnosis and has no awareness of his present physical functioning? Mr. E. seemed to be

protecting himself by denying his illness and attempting successfully to avoid discussion of family concerns, his physical condition and physical functioning. This style of coping was supposedly unrelated to physiological effects of the disease. Discussion was also made impossible by the fact that Mr. E. reacted to pain control medication by becoming delusional and confused. On the basis of the one in-depth discussion that this worker did have with Mr. E., his focus however seemed to be more on the past, as he was; rather than on the present.

Mr. E.'s almost outright detachment, combined with the family's distancing coping mechanisms seemed to mitigate against any meaningful involvement with his family. As Mr. E. seemed to protect himself by denial, the family gave the impression they were avoiding dealing directly with the reality and consequences of Mr. E.'s condition. Taken as a whole, the reaction of this family could be most aptly summed up as stoic. Such a situation obviates any possibility of developing a specific contract dealing with specific family issues relating to dying and bereavement for a specific period of time.

Speculatively, some observations and assumptions can be made concerning how this family's dynamics created their stoic, inattentive response to Mr. E.'s dying. Resistance to engaging with this social worker was very strong. To engage in any way would have meant that their line of stoicism was challenged. The relationship rule and organization around protecting Mrs. L., perhaps the family's weakest member, from the stress of the reality of Mr. E.'s condition, would have also been challenged and disturbed. A family conference was thereby definitely precluded by the relationship rule as information

about Mr. E.'s dying would have been discussed. This family had in effect given Mrs. L. permission to be weak, as shown by her drinking, so that the rest of the family could be strong. The protective, stoic stance of the family maintained Mrs. L.'s emotional dependency on her father and perhaps reinforced her alcoholism.

From an opposite point of view in terms of culturally and socially prescribed death denial, this family could be seen to be coping very well with their loss. Perhaps Mr. E. and his family had completed all their grief work before his admission to hospital. The family seemed devoid of emotional attachment, relationship or definition of relationship with Mr. E. It seemed that the family treated Mr. E. as if he was already dead. Decathexis on the part of family and Mr. E. may have already occurred.

VI. Mr. F.

Mr. F. was referred to this social worker by the Home Care Department. On referral, Mr. F. was an inpatient on an acute care ward for surgery. The concern motivating the referral was the apparent difficulty Mr. and Mrs. F. seemed to be having coping with his disease. They had persistently requested unorthodox laetrile treatment.

Mr. F. was a seventy-five year old man with recurrent complete, obstructive cancer of the large intestine with liver metastases. In the last year of his life, Mr. F. had abdominal surgery three times for his disease. Mrs. F. was sixty-six years of age. Following Mr. F.'s death, it became known that Mr. F.'s three children were from an earlier marriage. Mr. F. had been employed by the C.N.R. for fifty years as a boilermaker and had also operated a farm for forty years.

Worker activity began with an unannounced visit to Mr. F.'s bedside while he was still an inpatient. The purpose of this visit was to engage the family, begin assessment and develop a contract. As it happened, Mr. and Mrs. F. were seen together on the initial visit. Mr. and Mrs. F. seemed very concerned about Mr. F.'s diagnosis and prognosis. When asked, they acknowledged having requested and received information on laetrile treatment from an organization based in Tijuana, Mexico with a branch in North Dakota. Mr. F. had approached two chemotherapy specialists in Winnipeg for their help in arranging laetrile treatments in Winnipeg. The laetrile treatments were not regarded as therapeutic by the Canadian medical profession. Consequently Mr. and Mrs. F. had considered going to Tijuana, Mexico to obtain the treatment. Mr. F. also presented as very anxious to prepare his wife to handle their financial affairs on her own. He found this difficult however because Mrs. F. became upset when he initiated discussion of their affairs. Mr. F. indicated he responded to this by discussing their affairs a little at a time to desensitize his wife to the issues. Conversely, Mrs. F. seemed to be experiencing difficulty adjusting to her husband's condition and their new social situation with its increasing demands for new role adaptations. Mrs. F. seemed to interpret Mr. F.'s discussion of her assuming gradual control of their financial situation as "I'm leaving you." The planned discharge home, home care supports and possible 2ECU admission was discussed. To continue discussing the concerns expressed during this interview, it was agreed that this worker would visit the F.'s at home after Mr. F.'s discharge.

The visit was arranged and took place about one week after

discharge. Mr. F. openly expressed his reaction and feelings about his disease and dying. However Mr. F. seemed more resigned to dying than accepting death. It was very difficult for Mrs. F. to hear her husband talk about his death and dying. Mrs. F. seemed to avoid sharing her feelings. Most of Mrs. F.'s contribution to the interview centred around instrumental problems such as what plans should be made for the disposition of their home after Mr. F. dies and her current difficulty caring for her husband. In the course of the interview, Mrs. F. did not seem to be as dependent on her husband as had been thought previously. Mrs. F. revealed that she has a driver's licence and stated that she had taken control of their financial affairs. Mr. F. avoided responding to this statement by his wife with silence as if he felt his wife was not really in need of him.

Mr. and Mrs. F. seemed to be unwilling to bring the discussion around how their family was coping. Perhaps the relationships between Mr. and Mrs. F. and the children were somewhat strained given Mrs. F.'s position as step-parent.

The interview primarily centred around Mr. F.'s medication and the laetrile treatments he had been considering. Mr. F. drew a parallel between the experimental chemotherapy he had been offered and the laetrile treatment he wished to undertake. This worker reinforced what the F.'s had been told by the oncologists, specifically that laetrile treatments were of no benefit. So that the F.'s were not deprived of hope, it was pointed out that the chemotherapy offered previously was still available. Mrs. F. inquired whether it would be possible that Mr. F. may be given medication "to make it kill him," without his consent. The basis for this fear could not be

identified. At the conclusion of the interview, it was agreed that this social worker would contact the F.'s in about two weeks to set up another appointment to provide supportive counselling.

Shortly afterwards, Mr. F. was readmitted to hospital as his wife was having difficulty coping with his care at home. When this social worker visited Mr. F., he seemed to realize that he was close to death but had not given up hope. A few times he repeated: "God will help me." Four days later, Mr. F. died.

As Mrs. F. seemed possibly to be in need of support, it was decided to attempt to remain involved. To that end, this worker attended the funeral and telephoned Mrs. F. to express condolences a few days later.

Mrs. F. seemed to pretend she could not understand and ended the conversation by hanging up. Therefore in addition to the bereavement card sent by the ward, this worker sent one of his own. About a week later Mrs. F. called and spoke with a nurse from the Home Care Department. Mrs. F. asked who I was and then requested the Home Care nurse tell me not to phone again nor send any more cards. The same day Mrs. F. visited the ward to return the bereavement card sent by this worker. Apparently following the home visit to Mr. and Mrs. F., Mr. F. had warned his wife that this social worker's intention was personal rather than professional. To justify his belief he cited the fact that the social worker had placed his hand on Mrs. F.'s shoulder at some point. Mrs. F. therefore apparently interpreted the phone call and sympathy card as an advance. Supposedly a neighbour also reinforced this opinion. One of the Sisters from the Pastoral Care Department as well as one of the housekeeping staff who knew Mrs. F.

talked with her and clarified this worker's purpose.

Case Commentary--Themes and Issues

Mrs. F.'s hostility towards this social worker could be interpreted as anger directed at someone in the environment who was perceived to be an impediment to the recovery of her lost object. This anger would, as Bowlby describes, be related to the sorrow in the process as Mrs. F. strove to lessen the pain engendered by her grief and yearning for her dead husband. Mrs. F.'s hostility may have been the displacement of anger arising from a sense of guilt. Mrs. F. may have been feeling guilty from a secret sense of relief following the death. In retrospect, Mrs. F.'s reference to euthanasia could be regarded as perhaps a projection of some fleeting thoughts of her own about how she could end the misery for her husband and herself. Thus she could have been experiencing feelings of guilt which she demonstrated by displacing hostility towards this social worker. Mrs. F. also confided to a member of the housekeeping staff that in his last days, Mr. F. comforted her very little and actually sent her away once. Therefore, Mrs. F. may have misinterpreted her husband's deatathexis as a hurtful rejection which aroused a sense of anger which again, in turn, was displaced. A further complicating factor could be that as Mr. and Mrs. F. were unsophisticated and poorly educated with probably no previous social worker contact, they may have had serious difficulty comprehending this worker's purpose. Some of the misreading of this worker's body language in putting a hand on Mrs. F.'s shoulder during the home visit in February may have also been due to the cultural background of Mr. and Mrs. F. as well as their life experience. Essentially,

the symbolic act of placing a hand on a shoulder was interpreted to indicate a personal advance rather than a caring and concerned professionalism.

The hostility displayed by Mrs. F. can also be understood in terms of relationship dynamics between Mr. and Mrs. F. When Mr. F. warned his wife about his perception of this social worker's intentions, he may have been dealing with his own anger at dying. He desperately hoped to live and may have been concerned about the possibility that his wife one day would remarry as he himself had. In this respect he may have been reacting to his wife's anticipatory grief work and a partial withdrawal of emotional investment. To warn his wife about this worker may have been a symbolic warning to his wife that he disapproved of her establishing a relationship with any other man. Mr. F. may then have been attempting to remain socially alive for his wife despite his deteriorating condition. On the other hand, Mrs. F.'s hostility may have been for her a way of avoiding or delaying dealing with her grief. For Mrs. F. to engage this worker would have possibly increased any sense of guilt she may have had as she would have been disobeying her dying husband. Given the age and cultural background of the F.'s; the relationship rule, demanding that a wife unquestioningly obey her husband, may have been powerful. The necessity to obey may have been even stronger given the death of Mr. F. for had she disobeyed she would have almost been disloyal and betraying his memory. The description in the literature of the bereaved having visions of their deceased loved one, may also have some applicability here. Mrs. F. may have felt that if she did not obey, her husband may have been mystically aware. Accordingly,

Mr. F.'s warning was also a mystification. The issues of adjustment and a caring professionalism were misdefined as a sexual advance. Therefore in a very real way for Mrs. F., the hand on her shoulder was her husband's. She had been placed in a double bind. To resolve grief, the lost object must be replaced by new object(s) or relationships; however to do so may have been a betrayal of her husband's wishes.

When Mrs. F.'s hostility became known, further attempts to engage with Mrs. F. ceased as a trusting, therapeutic relationship could not exist. Instead, Mrs. F. was seen by a Sister from the Pastoral Care Department.

VII. Mrs. G.

Shortly after Mrs. G.'s admission to hospital, concern was expressed that Mrs. G.'s daughter, Dianne, was providing the major portion of Mrs. G.'s nursing. Following the weekly 2ECU case conference where this concern had been expressed by nursing staff, Mrs. G. was referred to this social worker.

Mrs. G. was a 53 year old woman who was admitted to 2ECU at the beginning of April 1980. She was complaining of pain and some nausea. Mrs. G. was suffering from cancer of the breast with bone metastases. She had been married for 29 years and had been separated for 8 years because of her husband's excessive drinking. Mrs. G. occasionally saw her husband on visits but indicated that she considered him nothing more than a friend. Mr. G. was self-employed as a truck-driver. Mrs. G. reported that she also left her husband because he had been unfaithful and was currently living with another woman.

The client system consisted of Mrs. G., Dianne, Dianne's husband Victor and their four elementary school age children. Prior to admission to hospital, Mrs. G. had been residing with and had been cared for by her daughter Dianne and her family. Mrs. G. felt her care at home had been too much for Dianne. It was noticed that Victor did not visit Mrs. G. in hospital. In the course of her separation with Mr. G., Mrs. G. lived with Les whom she referred to as her boyfriend. As Mrs. G. did not seem to have a relationship with either Les or Mr. G. they were not treated as part of the client system. They also did not visit Mrs. G. in hospital.

Given the concern of nursing staff that Dianne was spending up to twelve hours per day performing most of the care her mother required, the initial goal of this social worker's involvement was to assess the family situation. On the first visit with Mrs. G., Dianne and a niece were present. When asked by the social worker about her diagnosis and prognosis, Mrs. G. responded that she had cancer and expected to die. Mrs. G. restrained her tears at this point while Dianne began and continued crying for some time. Mrs. G. talked about herself as a burden to her family almost implying that their lives would be easier with her death. She described herself as interfering with Dianne's home life. Mrs. G. elaborated by expressing criticism of Victor, Dianne's husband, because he is "childlike, irresponsible and unemployed." Dianne made only a feeble attempt to respond to her mother's ill feelings towards Victor by claiming that all the bills were paid. Both Mrs. G. and Dianne were not receptive to a meeting with Victor to deal with the evident conflict between them.

As arranged, one week later this worker had a further interview

with Mrs. G. which was very lengthy and took the form of a life review. Mrs. G. had Dianne bring albums of snapshots from home which Mrs. G. invited this worker to go through with her. Reviewing the albums helped Mrs. G. Talk about her marital disappointment and her relationship with the boyfriend, Les. Mrs. G. found her relationship with Les rewarding and fulfilling but disappointing too as the relationship ended with the occurrence of her cancer. Mrs. G. began reviewing her relationship with Dianne. She was obviously concerned about impressions this worker may have drawn about Dianne's prolonged crying during the previous interview. Mrs. G. attempted to explain very carefully that she was "mean" to Dianne at various times during her childhood. She then qualified "mean" in terms of impatience and being unable to provide material things because of poverty. Mrs. G. was reassured that Dianne's reaction was an appropriate, healthy expression of emotion.

As nursing staff had noticed that Mrs. G. became nauseous and vomitted whenever she seemed to be emotionally upset, Mrs. G.'s nausea and vomitting were discussed. Mrs. G.'s physician had previously indicated at the weekly case conference that the reason for Mrs. G.'s nausea and vomitting was emotional rather than physical. The hypothesis that her nausea and vomitting was related to emotional upset was put to Mrs. G. as an observation. Mrs. G. rejected the hypothesis and attempted to dismiss the subject by attributing her recurrent nausea and vomitting to becoming "nervous in the stomach." Very shortly after Mrs. G. made this observation, her roommate died. Nursing staff were notified but before they attended, this worker returned to find Mrs. G. becoming nauseous. As this worker held Mrs. G.'s

forehead in one hand and a kidney basin with the other, Mrs. G. retched violently and vomitted. Once recovered, Mrs. G. then reviewed her experience with her roommate since her admission and shared some feelings of fear. It was again suggested to Mrs. G. that a possible reason for her nausea and vomiting was emotional upset. While not rejecting the observation outright, Mrs. G. seemed reluctant to deal with the issue. Perhaps she had come face to face with the awareness of fear of death.

About two weeks later the head nurse and physician described Mr. G., mentioning that Dianne's husband, Victor, had been telling the grandchildren that Mrs. G.'s cancer developed from syphilis. The physician and head nurse offered Mrs. G. the possibility of a family conference. As a member of the 2ECU team, this worker explored the idea of the family conference further with Mrs. G. to clarify its purpose and develop an interventive strategy.

Mrs. G. felt a family conference would take some of the pressure off her. However Mrs. G. stipulated that she did not want Victor to get the impression that she had asked for him "to be straightened out." She concluded that she would prefer that the family conference be held after she died to try to maximize Victor's guilt. Her words were: "so that certain people could have guilty consciences." Mrs. G. felt very hurt and angered by Victor's statements although she seemed to appreciate that she did not contract cancer as a result of having had any contact with syphilis. When it was pointed out to Mrs. G. that this approach would be very punishing for Victor with no hope of forgiveness, Mrs. G. terminated the interview by complaining of abdominal cramps and leaving for the washroom. Being confronted in this way

seemed to anger Mrs. G. as she had assumed an alliance existed between her and this worker. Mrs. G.'s abrupt departure could also have been indicative of resistance aroused as a result of the challenge made to her sick role. The secondary gain issue of Mrs. G.'s illness in how it affected her relationships and how she proposed to use her illness was also confronted so that rapport had been momentarily destroyed.

The possibility of having a family conference required further discussion with Mrs. G. If the conference would be used for potentially destructive purposes then it would be questionable if there should be one at all. Conversely it seemed that the triangulated conflict between Mrs. G., Dianne and Victor should be addressed for the communication system to be opened and conflict to be resolved. In meeting with Mrs. G. again, Dianne happened to be visiting. Dianne left the room briefly. Mrs. G. hastily stated in a muted voice that she did not want to do anything that would make further trouble while she was alive. When Dianne returned, Mrs. G. resumed talking normally about a totally unrelated subject. This piece of interaction suggested that Mrs. G. may have been referring to the family conference. To check this out, Mrs. G. was asked if she still wanted a family conference to occur. With the participation of Dianne and Mrs. G., a contract was worked out to provide information regarding Mrs. G.'s condition in a family conference.

A few days later, the family conference was held at Mrs. G.'s bedside with Dianne, Victor's sister, Mrs. G.'s physician, her nurse and this social worker. The physician stated clearly that cancer cannot be caused by contact with venereal disease or infection. Concern

was expressed by this social worker and the nurse that Mrs. G. seemed to be requiring Dianne to perform the bulk of the nursing she needed. Dianne and Mrs. G. responded with resistance and justified the status quo in their relationship. Mrs. G. seemed to find Dianne's solicitous behavior as a comfort given the pain she had begun to experience. Victor's absence was acknowledged by this worker but was not dealt with. Possibly the presence of Victor's sister meant that Victor was there by proxy to protect him from any expected direct attack from the team. His sister's presence suggested that she may have been asked to attend so that a message would nonetheless be carried back to Victor.

Concern continued to be expressed by nursing staff about the amount of time Dianne was spending on the ward caring for her mother. This concern was genuine and not just the expression of a need to be needed by nursing staff. Dianne appeared to be driving herself to the point of physical exhaustion. The tactic of meeting Dianne and her mother together did not seem to work when this issue was discussed in the past. Seen together, Dianne and her mother automatically colluded to defend the status quo of their relationship in the hospital setting. Their combined resistance seemed very strong when they were dealt with together as a family. Their resistance seemed to close off communication which made it very difficult to help them become aware of their interaction. Both Mrs. G. and Dianne appeared to be unaware of how their relationship was meeting their needs in the context of dying and bereavement. Therefore, instead of meeting together with them as a family, this worker decided to meet with them individually as a family. The approach used in the context of both meetings was to

introduce the observation that Mrs. G. and Dianne seemed to fear the loss of each other through serious illness and possible death. In terms of their behavior, it was shown that Mrs. G. "saved things" for Dianne to do; while Dianne was visibly reaching the point of exhaustion. Using this tactic and strategy seemed to produce some growth for Mrs. G. and Dianne. They both seemed to consider their relationship patterns dispassionately for the first time since this worker's involvement.

As this worker's term at the hospital was concluding, this worker terminated with Mrs. G. and Dianne. Further involvement was assumed by the 2ECU social worker. Shortly after this termination, Mrs. G. died.

Case Commentary--Themes and Issues

Involvement with the G. family demonstrates that one of the ways a family maintains a closed communication system is by means of boundaries. The family members that this worker was involved with appeared to have their own emotional boundaries which regulated who was permitted to be involved and how. The family system also had created an internal boundary around Victor and Mrs. G. to disengage them from their conflict by means of a de facto agreement to avoid each other. As Dianne continued to provide the care for her mother in hospital, it seems that the perhaps primary reason for the hospitalization was to separate Mrs. G. and Victor. At home the situation between the two of them may have been impossible given their enmeshed preoccupation with each other's weaknesses. The emotional triangle between Mrs. G., Dianne and Victor embodied a competition and struggle between Mrs. G. and Victor for Dianne's attention and affection. In

the creative way that families find solutions to their problems, this family achieved a degree of detriangulation by means of Mrs. G.'s admission to hospital. Their final detriangulation would be created by Mrs. G.'s death. Or would it? If Dianne did not forgive Victor for the terrible things he said about her mother, they could continue to triangulate with the deceased Mrs. G. Perhaps this pattern of relationship would continue to exist until they were able to triangulate with someone else, possibly one of their four children. Attempting to work together with Dianne and Mrs. G. was impossible as they triangulated with this worker. Hence, with the triangulation, the full brunt of resistance was felt. As Victor was unwilling to be present or was kept away from the family conference, the only possible way of doing therapy was to work alone with Mrs. G. and Dianne.

Dianne was being forced into a double bind. Victor seemingly could not tolerate Dianne's closeness with her mother, while Mrs. G. could not tolerate Dianne's ties with Victor. Dianne must have felt like she was being faced with an impossible choice. On the one hand, Dianne must have felt like it was a "crime" to care for her mother; while on the other it was a "crime" to neglect her home and family. From Victor, Dianne was hearing how "sinful" and "evil" her mother was and how she was paying for her past wrongdoings. Meanwhile Dianne was manipulated by Mrs. H. so that she thought her mother still depended on her for a major part of her care. This would have been impossible if Dianne had been assertive enough to define herself by saying no to her mother. But how could she possibly say no to her dying mother? She could not say no probably because she felt a sense of misplaced responsibility and guilt for what Victor had been

saying.

Moreover, the boundaries erected in this family helped to attenuate their grief. Dianne and her mother became totally absorbed and involved in the specific, instrumental issues relating to hospital care. Thus, they were able to limit and restrict reflection on the process in their family and avoid dealing with the issues of dying and bereavement. The contract in this family, seen in its symptoms, therefore allowed the family to maintain an at best unstable equilibrium, permitting the family to continue functioning.

VIII. Mr. H.

Before this social worker became involved with the H. family, Mr. H. had been a patient on 2ECU for more than a month. Initially Mr. H. had been admitted for a two-week period of social relief while his wife dealt with instrumental problems. Following admission, it became apparent that Mr. H. and his family would have difficulty coping at home because of his physical deterioration and a poor support system. The H. family was transferred to this social worker as the previous social worker was leaving the hospital and the family seemed to be in obvious need.

The client system consisted of fifty-five year old Mr. H. who was suffering from amyotrophic lateral sclerosis, also known as motor neuron disease. Mr. and Mrs. H. were married for thirty-four years and had three children. Lorraine, eleven years of age, remained at home with her mother. A son Richard age thirty-two and a daughter age twenty-eight both lived in the city and had their own families.

Mr. H. was observed to be severely limited in his walking ability

and manual dexterity as a result of his disease. He was emotionally labile with abrupt mood swings ranging from broad smiles to sudden tears. Mrs. H. had been managing to support herself and Lorraine by means of employment until she decided to take a three-month leave of absence for what she described as "pressure in household chores."

Prior to this social worker's involvement, a history of marital conflict and current issues in the marital relationship became apparent. Mr. H. confided to his previous social worker that he had had desires and fantasies of a sexual nature over the years which his wife was never able to satisfy. Mr. H. mentioned that in the past he had frequently seen erotic movies and read similar material. Mrs. H. had also independently described (to the previous social worker) a meeting with a very friendly couple only to discover that they were members of a nudist colony which her husband wanted to join. Mrs. H. was angry and indignant when she learned the purpose of the meeting. During a visit home on a pass from hospital, an embarrassing argument had developed in front of relatives. Mrs. H. had also mentioned that on other visits home and during hospital visits as well she found her husband particularly demanding. On one occasion at home on a visit, Mr. H. had told Lorraine: "If you don't do this I'll hit you."

The basic goal of this worker's involvement seemed to be to assist Mr. and Mrs. H. deal with the outstanding issues of marital conflict within the context of adaptation to dying and bereavement. The possibility of discharge was discussed at the weekly case conference on the ward. If Mr. H. did return home it seemed that the aforementioned goals would be particularly important and relevant to the family. Mr. and Mrs. H. were receptive to discharge planning. A

family conference was arranged. However, just before the conference was to occur, Mrs. H. asked that her husband not be present as she thought "it would be too difficult for him." Mrs. H. insisted that she would not discuss the subject of who should attend with her husband. The request was discussed with Mr. H. who agreed. As the H.'s adult son and daughter had made special arrangements to come to the hospital during the day, the other members of the team agreed that the conference would proceed. Mrs. H. raised numerous objections to the suggestion of discharge home despite the offer of numerous Home Care supportive services. As he had requested to be informed of the conference's outcome, Mr. H. was advised that it seemed that he would be remaining in hospital. Without emotion and without saying anything else he responded: "That's fine."

From that point for the next four months Mr. H. was visited for about half an hour once per week by this worker. During this time period, Mr. H.'s condition continued a gradual but steady deterioration. He became unable to walk whatsoever and seemed to give up attempting to feed himself. Mr. H. seemed to avoid raising any concerns about his condition or his family. At the end of the fourth month, Mrs. H. contacted this worker and reported that Mr. H. was annoyed by this worker's inquiries about his family. This worker's purpose was clarified for Mrs. H. specifically, the point was made that just as Mr. H.'s condition was difficult for him, it must also be difficult for the family. This worker's purpose was to be available to assist the family to deal with any issues that presented. Mrs. H. seemed to accept this explanation and indicated that it might be helpful to meet with the family to discuss the current situation. Mrs. H. insisted

that the social worker should discuss the possibility of the family conference with Mr. H. When the prospect of another family conference was discussed with Mr. H., he rejected the idea outright. He stated that unless the purpose of a conference was to discuss a new treatment or cure, it would otherwise be "only horsing around." From having seen Mr. H. for a number of months, Mr. H. obviously needed to control his own life in whatever ways were left to him. Consequently, it seemed that the best way to deal with Mr. H.'s annoyance with this worker was to give him control over whether or not this worker continued to see him. Mr. H. maintained that the weekly meetings could continue but emphasized that he would like to talk about other things than his illness and his family. He suggested the news as an alternative. A few more meetings took place with Mr. H. on this social basis until termination occurred with the conclusion of this worker's term at the hospital.

Case Commentary--Themes and Issues

It would seem that the conflict and sense of marital disappointment in the relationship between Mr. and Mrs. H. were long-standing issues but were focussed and exacerbated by his disease. Mr. H. having been a self-motivating private entrepreneur was faced with a situation in which he felt absolutely no sense of control. He was no longer in control of his own body nor family affairs. With these insults to his dignity and sense of pride, there appeared to be serious implications for him in terms of sexuality and self-image as an active, self-reliant, strong individual. Mrs. H.'s objections to taking her husband home were probably founded in their simmering

marital conflict. Owing to their relationship difficulties, it would probably have already been too awkward, stressful and difficult for Mrs. H. with her husband at home. Possibly Mrs. H. feared that saying she could not take her husband home in front of him would be interpreted as rejection; hence, she insisted on Mr. H.'s absence from the family conference. Mr. H.'s subsequent unwillingness or motivation to participate in the family conference suggested by his wife could have been related to Mrs. H.'s request that he be absent from the first conference. However by that time, Mr. H. also seemed totally caught up in himself. He could not perceive any reality beyond his own basic survival needs for food, water and comfort. This possible return to child-like primary narcissism could also be an indication of the beginning of Mr. H.'s deatthesis. His refusal to consider another family conference could have been a symbolic indication that for him dying meant only death with no opportunity for resolving past conflicts.

The H. family illustrates how a closed system of communication allows a family to continue functioning in spite of profound unfinished business. Mr. and Mrs. H. seemed to have reached some degree of balance or accommodation which allowed their unfinished business to recede from the figure to the ground of their relationship. A closed communication system can seductively elicit the support of helping professionals. This social worker was totally inducted into their closed communication system by hoping to find an opening that spontaneously occurred rather than strategically creating one. A paradoxical intervention that would have used the strength of their resistance to open the communication system may have been more effective. When the first family conference format was being changed by Mrs. H.,

perhaps, a more appropriate response would have been to prescribe no change. It could have been suggested that this may not be the right time for the family conference. Their concern for each other's feelings could have been highlighted as something too precious to be jeopardized by talking too openly.

BIBLIOGRAPHY

- Ackerman, N. W. Family Process. New York: Basic Books, 1970.
- Ackerman, N. W. Treating the Troubled Family. New York: Basic Books, 1966.
- Aguilera, D. C. and Messick, J. M. Crisis Intervention Theory and Methodology. St. Louis: C. V. Mosley Company, 1978.
- Arndt, H. and Gruber, M. "Helping Families Cope with Acute and Anticipatory Grief," Pritchard, E. R., Collard, J., Or #, B. A., Kutscher, A. H., Seeland, I., Lefkowitz, N. (eds.) Social Work With the Dying Patient and the Family. New York: Columbia University Press, 1977.
- Bandler, R. and Grinder, J. The Structure of Magic I and II: A Book About Language and Therapy. Palo Alto: Science and Behaviour Books, 1975.
- Barker, E. (ed., trans.) The Politics of Aristotle. New York: Oxford University Press, 1969.
- Barry, H. "Significance of Maternal Bereavement before the Age of Eight in Psychiatric Patients," Archives of Neurological Psychiatry, 62, 1949, pp. 630-637.
- Bateson, G., Jackson, D., Haley, J., and Weakland, J. "Toward a Theory of Schizophrenia," Behavioural Science I, 1956, pp. 251-254.
- Becker, E. The Denial of Death. New York: The Free Press, 1973.
- Beecher, H. K. "Nonspecific Forces Surrounding Disease and the Treatment of Disease," Journal of the American Medical Association. 1962, pp. 179, 437-40.
- Beilin, R. "Social Functions of Denial of Death," Omega. 12(1), 1981-82, pp. 25-35.
- Benda, C. E. "Bereavement and Grief Work," Journal of Pastoral Care. 1962, pp. 16, 1-13.
- Bermaun, E. Scapegoat: The Impact of Death-Fear on an American Family. Detroit: University of Michigan Press, 1973.
- Binger, C. M. et al. "Childhood Leukemia; Emotional Impact on Patient and Family," New England Journal of Medicine. 1969, p. 280.

- Birk, A. "The Bereaved Child," Mental Health. 25(4), 1966, pp. 9-11.
- Bowen, M. "Family Reaction to Death," Guerin, P. (ed.) Family Therapy: Theory and Practice. New York: Gardner Press, 1976.
- Bowers, M., Jackson, E., Knight, J., and LeShan, L. Counselling the Dying. New York: Nelson, 1964.
- Bowlby, J. "Separation Anxiety," International Journal of Psychoanalysis. 1940, pp. 89-113.
- _____. "Some Pathological Processes Engendered by Early Mother-Child Separation," British Journal of Psychiatry, 99, 1953, pp. 265-72.
- _____. "Childhood Mourning and its Implications for Psychiatry," American Journal of Psychiatry, 1961, pp. 118, 481-498.
- _____. "Processes of Mourning," International Journal of Psychoanalysis, 1961, pp. 42, 317-40.
- _____. "Pathological Mourning and Childhood Mourning," Journal of the American Psychoanalytic Association, 1963, pp. 500-541.
- _____. Attachment and Loss. New York: Basic Books, 1977.
- _____. Separation: Anxiety and Anger, Volume 2 of Attachment and Loss. New York: Basic Books, 1977.
- Brodsky, B. "The Self-Representation, Analogy and the Fear of Dying," Journal of the American Psychoanalytic Association. 1959, pp. 7, 95-108.
- Burton, A. "Death as a Countertransference," Psychoanalytic Review. 49, 1962, pp. 3-20.
- Cain, A. C., Fast, I., and Erickson, M. E. "Children's Disturbed Reactions to the Death of a Sibling," American Journal of Orthopsychiatry. 34(2), 1964, pp. 741-52.
- Caine, Lynn. Widow. New York: Bantam, 1975.
- Camus, A. The Myth of Sisyphus. New York: Vintage/Random House, 1961.
- Castaneda, C. Journey to Ixtlan. New York: Simon and Shuster, 1975.
- Caplan, G. "An Approach to the Study of Family Mental Health," M.S. Public Health Reports. 71(10), 1956, p. 1027.
- Choron, J. Death and Modern Man. New York: Collier, 1964.
- Corey, G. Theory and Practice of Counselling and Psychotherapy. Monterey: Brooks/Cole, 1977.

- Christ, A. E. "Attitudes Toward Death Among a Group of Acute Geriatric Psychiatric Patients," Journal of Gerontology, 1961, 16, pp. 56-59.
- Davidson, G. Living with Dying. Minneapolis: Augsburg Publishing House, 1975.
- Davis, R. H. and Neiswender, M. Dealing with Death. Ethel Percy Andrews Gerontology Centre, University of Southern California, 1973.
- De Beauvoir, S. A Very Easy Death. Harmondsworth: Penguin Books, 1969.
- Donne, J. Biathanatos. New York: Arno Press, 1976.
- Eissler, K. The Psychiatrist and the Dying Patient. New York: International Universities Press, 1955.
- Eliot, T. D. "The Adjustive Behaviour of Bereaved Families: A New Field of Research," Social Forces. 8, 1930, pp. 543-49.
- _____. "Bereavement as a Field of Social Research," Bulletin of the Society of Social Research. 17, 1938, p. 4.
- _____. "Bereavement as a Problem of Family Research and Technique," The Family. 11, 1930, pp. 114-15.
- _____. "A Step Toward Social Psychology of Bereavement," Journal of Abnormal and Social Psychology. 27, 1933, pp. 380-90.
- Ellard, J. et al. Normal and Pathological Responses to Bereavement. New York: M.S.S. Information Corporation, 1974.
- Elliot, G. Twentieth Century Book of the Dead. London: Allen Lane, Penguin Press, 1972.
- Ellis, A. Reason and Emotion in Psychotherapy. New York: Lyle Stuart, 1963.
- Engel, G. L. "Is Grief a Disease?" Psychosomatic Medicine. 23, 1961.
- Erickson, G. D. and Hogan, T. P. Family Therapy: An Introduction to Theory and Technique. Monterey: Wadsworth, 1972.
- Erickson, R. and Hyerstay, R. "The Dying Patient and the Double Bind Hypothesis," Omega. 5, 1974, pp. 287-98.
- Erikson, E. H. Childhood and Society. New York: W. E. Norton and Company, 1963.
- _____. Identity Youth and Crisis. New York: W. W. Norton and Company, 1968.

- Evans-Wentz, W. E. (ed.). The Tibetan Book of the Dead. New York: Oxford University Press, 1927.
- Farberow, N. L. and Shneidman, E. S. The Cry for Help. New York: McGraw-Hill, 1965.
- Feifel, H. (ed.). The Meaning of Death. New York: McGraw-Hill, 1959-1965.
- _____. New Meanings of Death. New York: McGraw-Hill, 1977.
- _____. "The Function of Attitudes towards Death," Death and Dying. Attitudes of Patient and Doctor. New York: Group for the Advancement of Psychiatry, 1965.
- Feigenberg, L. "Care and Understanding of the Dying: A Patient-Centered Approach," Omega. 6, 1975, pp. 81-94.
- Feigenberg, L., and Shneidman, E. S. "Clinical Thanatology and Psychotherapy: Some Reflections on Caring for the Dying Person," Omega. 10(1), 1979, pp. 1-8.
- Feldman, M, J. et al. Fears Related to Death and Suicide. New York: M.S.S. Information Corporation, 1974.
- Foster, L. E., Lindemann, E., and Fairbanks, R. J. "Grief," Pastoral Psychology. 1(5), 1950, pp. 28-30.
- Frankl, V. E. "Psychiatry and Man's Quest for Meaning," Journal of Religion and Health. 1962, pp. 93-103.
- _____. The Unconscious God. New York: Simon and Schuster, 1975.
- _____. The Doctor and the Soul. New York: A. A. Knopf, 1965.
- _____. Psychotherapy and Existentialism: Selected Papers on Logotherapy. New York: Simon and Shuster, 1967.
- _____. From Death Camp to Existentialism: A Psychiatrist's Path to New Therapy. Boston: Beacon Press, 1959.
- _____. The Will to Meaning: Foundations and Applications of Logotherapy. London: Souvenir Press, 1971.
- _____. Man's Search for Meaning: An Introduction to Logotherapy. Boston: Beacon Press, 1963.
- Freeman, D. S. Techniques of Family Therapy. New York: Aronson, 1981.
- Freud, S. "Mourning and Melancholia" (1917) Collected Papers. New York: Basic Books, 1959, Vol. 4.
- Fromm, E. Marx's Concept of Man. New York: Frederick Nugar, 1970.

- Fulton, R. (ed.) Death and Identity. Bourie MC. Charles Press, 1976.
- Fulton, R. L. "Death and the Self," Journal of Religion and Health. 3(4), 1964, pp. 359-68.
- Glaser, B. G. and Strauss, A. L. "The Social Loss of Dying Patients," American Journal of Nursing. 65, 1964, pp. 119-21.
- Granville-Grossman, K. L. "Early Bereavement and Schizophrenia," British Journal of Psychiatry. 1966, 112, pp. 1027-34.
- Hardt, D. V. "An Investigation of the Stages of Bereavement," Omega. 9(3), 1978, pp. 279-85.
- Hill, O. W. and Price, J. S. "Childhood Bereavement and Adult Depression," British Journal of Psychiatry. 1967, pp. 743-51.
- Gandhi, M. K. Why Fear or Mourn Death? Bombay: Bharatuja Vidya Bhavan, 1971.
- Garfield, C. A. (ed.) First National Training Conference for Physicians on Psychosocial Care of the Dying Patient. San Francisco: University of California School of Medicine, 1976.
- Gerber, I. et al. Perspectives on Bereavement. New York: Arno Press, 1979.
- Glaser, B. G. and Strauss, A. L. Awareness of Dying. Chicago: Aldine Publishing Company, 1966.
- Glick, I., Weiss, R. J., and Parkes, C. M. The First Year of Bereavement. New York: Weley and Sons, 1974.
- Goldstein, E. and Malitz, S. "Psychotherapy and Pharmacotherapy as Enablers in the Anticipatory Grief of a Dying Patient: A Case Study," Schoenberg, B., Carr, A., Kutscher, A., Peretz, D., Goldberg, I. (eds.) Anticipatory Grief. New York: Columbia University Press, 1974.
- Gordon, R. Dying and Creating: A Search for Meaning. London: The Society of Analytical Psychology Ltd., 1978.
- Gray, W. et al. (eds.) General Systems Theory and Psychiatry. Boston: Little Brown, 1969.
- Grollman, E. A. Talking About Death. Boston: Beacon Press, 1970.
- Group for Advancement of Psychiatry. Death and Dying: Attitudes of Patient and Doctor. New York: Symposium II. 1965/1972.
- Guerin, P. (ed.) Family Therapy: Theory and Practice. New York: Gardner Press, 1976.

- Gunther, J. Death Be Not Proud. Harper and Row, 1971.
- Haley, J. (ed.) Changing Families. New York: Greene and Stratton, 1971.
- Haley, J. Uncommon Therapy. New York: Ballantine Books, 1974.
- Hersen, M. and Barlow, D. Single Case Experimental Designs. Toronto: Pergamon Press, 1977.
- Hersen, M. and Bellack, A. Behavioural Assessment. Toronto: Pergamon Press, 1977.
- Hickey, T. Grief: It's Recognition and Resolution. Pittsburgh: College of Human Development, 1975.
- Hinsie, L. E. and Campbell, R. J. Psychiatric Dictionary (Fourth Edition). New York: Oxford University Press, 1970.
- Hinton, J. Dying. Harmondsworth and Baltimore. Pelican Books, 1972.
- Holmes, T. H. and Rabe, R. H. "The Social Readjustment Rating Scale," Journal of Psychosomatic Research. 11, 1967, pp. 213-18.
- Howard, A. and Scott, R. A. "Cultural Values and Attitudes Toward Death," Journal of Existentialism. 6, 1965-66, pp. 161-174.
- Jackson, E. N. Understanding Grief: It's Roots, Dynamics and Treatment. Nashville: Abingdon Press, 1957.
- Jackson, J. K. "The Adjustment of the Family to Alcoholism," Marriage and Family Living. 18(4), 1956, pp. 361-69.
- Johnson, R. E. Existential Man: The Challenge of Psychotherapy. New York: Pergamon Press, 1971.
- Jones, T. T. "Dignity in Death: The Application and Withholding of Interventive Measures," Journal of the Louisiana Medical Society, 113(5), 1961, pp. 180-83.
- Joseph, F. "Transference and Counter-transference in the Case of a Dying Patient," Psychoanalysis and Psychoanalytic Review. 49(4), 1962, pp. 21-34.
- Jung, Y. L. Death and Beyond in the Eastern Perspective. New York: an Interface Book, 1974.
- Kalish, R. "The Onset of the Dying Process," Omega. 1, 1970, pp. 57-69.
- _____. "Dealing with the Grieving Family," Registered Nursing. 26, 1963, pp. 81-84.

- Kalish, R. A. "Social Distance and the Dying," Community Mental Health Journal. 2(2), 1966, 152-55.
- Kapleau, P. The Wheel of Death. New York: Harper and Row, 1971.
- Kastenbaum, R., Geddes, G., Truman, G., and Simpson, M. A. Death as a Speculative Theme in Religious, Scientific and Social Thought. New York: Arno Press, 1976.
- Kastenbaum, R. (ed.) Between Life and Death. New York: Springer Publishing Company, 1979.
- Kastenbaum, R. Death, Society and Human Experience. St. Louis: C.V. Mosby, London: Henry Krimpton, 1981.
- Kavanaugh, R. E. Facing Death. Los Angeles: Nash Publishing, 1972.
- Kazden, A. E. and Wilson, G. T. Evaluation and Behavioural Therapy. Cambridge: Balinger Publishing Company, 1978.
- Kidorf, I. W. "Jewish Tradition and the Freudian Theory of Mourning," Journal of Religion and Health. 2, 1963, pp. 248-52.
- Kierkegaard, S. Fear and Trembling and the Sickness Unto Death. New York: Doubleday, 1954.
- Killilea, A. G. "Death Consciousness and Social Consciousness: A Critique of Ernest Becker and Jacques Choron on Denying Death," Omega. 11(3), 1980, pp. 185-200.
- Kimmel, D. C. Adulthood and Aging. New York: Wiley and Sons, 1974.
- Klein, M. "Mourning and Its Relation to Manic Depressive States," International Journal of Psychoanalysis, 21, 1940, pp. 125-53.
- Kligfeld, B. and Krupp, G. "Sexual Adjustment of Widows," Sexology. November, 1966, pp. 230-33.
- Krupp, G. R. "Identification as a Defence Against Anxiety in Coping with Loss," International Journal of Psychoanalysis. 46, 1965, pp. 303-14.
- Kubler-Ross, E. "Psychotherapy for the Dying Patient," Current Psychiatric Therapies. 10, 1970, pp. 110-117.
- _____. "Death Does Not Exist," The Coevolution Quarterly. 3, 1977, pp. 100-107.
- _____. On Death and Dying. New York: Macmillan, 1968.
- _____. Questions and Answers on Death and Dying. New York: Macmillan, 1979.

- Kubler-Ross, E. Death: The Final Stage of Growth. New Jersey: Spectrum Prentice-Hall, 1975.
- Kutscher, A. H. Death and Bereavement. Springfield, Illinois: C.C. Thomas, 1969.
- Laing, R. D. The Politics of Experience. Harmondsworth: Penguin Books, 1967.
- _____. The Politics of the Family. Toronto: Hunter Rose Company, 1969.
- _____. Self and Others. Harmondsworth: Penguin Books, 1969.
- Lamm, M. The Jewish Way in Death and Mourning. Flushing, New York: Jonathan David Publishing, 1969.
- LeShan, L. and LeShan, E. "Psychotherapy and the Patient with a Limited Life Span," Psychiatry. 24(4), 1961, pp. 318-23.
- Lewis, C. S. A Grief Observed. London: Faber and Faber, 1961/1973. New York: Scabury Press, 1973.
- Lidz, T. The Person. New York: Basic Books, 1968.
- Lifton, R. J. and Olson, E. Living and Dying. New York: Praeger, 1974.
- Lindemann, E. "Symptomatology and Management of Acute Grief," American Journal of Psychiatry. 101, 1944, pp. 141-48.
- Lipson, C. "Denial and Mourning," International Journal of Psychoanalysis. 44, 1963, pp. 104-7.
- Lloyd, G. "The Expression of Grief as Deviant Behavior in American Culture," Pritchard, E. R., Collard, J., Orcutt, B. A., Kutscher, A. H., Seeland, I., Lefkowitz, N. (eds.) Social Work with the Dying Patient and the Family. New York: Columbia University Press, 1977.
- Marks, E. Simone De Beauvoir: Encounters with Death. New Brunswick, New Jersey: Rutgers University Press, 1973.
- Marris, P. Loss and Change. New York: Pantheon Books, Random House, London: Routledge and Kegan Paul, Doubleday Anchor, 1975.
- Martocchio, B. C. Living While Dying. Bowie, Md.: Robert J. Brady, 1982.
- McKittrick, D. "Counselling Dying Clients," Omega. 12(2), 1981-82, pp. 165-187.
- Menninger, K. Man Against Himself. New York: Harvest Books, 1966.

- Meyer, J. E. Death and Neurosis. New York: International Universities Press, 1975.
- Minuchin, S. Families and Family Therapy. Cambridge: Howard University Press, 1974.
- Minuchin, S. and Fishman, H. C. Family Therapy Techniques. Cambridge: Harvard University Press, 1981.
- Nicholi, A. M. The Harvard Guide to Modern Psychiatry. Cambridge and London: Harvard University Press, 1978.
- Norton, J. "Treatment of a Dying Patient," Psychoanalytic Study of the Child. 18, 1963, pp. 541-60.
- Noyes, R., Clancy, J. "The Dying Role: Its Relevance to Improved Patient Care," Psychiatry. 40, 1977, pp. 41-47.
- Nursing Skillbook. Dealing with Death and Dying. Nursing 77 Books. Intermed Communications: Jenkenstown, Pennsylvania, 1976.
- Orcutt, B. "Stress in Family Interaction When a Member is Dying: A Special Case for Family Interviews," Pritchard, E. R., Collard, J., Orcutt, B. A., Kutscher, A. H., Seeland, I., Lefkowitz, N. (eds.) Social Work with the Dying Patient and the Family. New York: Columbia University Press, 1977.
- Orcutt, B. A., Prichard, E. R., Collard, J., Cooper, E. F., Kutscher, A. H., and Seeland, I. B., (eds.) Social Work and Thanatology. New York: Arno Press, 1980.
- Parad, H. J. (ed.) Crisis Intervention: Selected Readings. New York: Family Service Association of America, 1965.
- Parad, H. J., Resnik, H. L. P., Parad, L. G. (eds.) Emergency and Disaster Management: A Mental Health Sourcebook. Bowie, M.D.: Charles Press, 1976.
- Parkes, C. M. Bereavement: Studies of Grief in Adult Life. New York: International Universities Press, 1972.
- _____. "Home or Hospital? Terminal Care as Seen by Surviving Spouses," Journal of the Royal College of General Practitioners, 28, 1978, pp. 19-30.
- _____. "Components of the Reaction to Loss of a Limb, Spouse, or Home," Journal of Psychosomatic Research. 16, 1972, pp. 343-49.
- _____. "Bereavement and Mental Illness. Part II: A Classification of Bereavement Reactions," British Journal of Medical Psychology. 38, 1965, pp. 13-26.
- _____. "Bereavement and Mental Illness: A Clinical Study," British Journal of Medical Psychology. 38, 1965, pp. 1-12.

- Parkes, C. M. "Broken Heart: A Statistical Study of Increased Mortality Among Widows," British Medical Journal. 42, March 1969, pp. 18-41.
- _____. "Effects of Bereavement on Physical and Mental Health--A Study of the Medical Records of Widows," British Medical Journal, 2, 1964, pp. 274-79.
- _____. "Recent Bereavement as a Cause of Mental Illness," British Journal of Psychiatry. 110, 1964, 198-204.
- Pattison, E. M. "The Experience of Dying," American Journal of Psychotherapy. 21, 1967, pp. 32-43.
- _____. The Experience of Dying. New Jersey: Spectrum/Prentice-Hall, 1976.
- Paul, N. L., and Grosser, G. H. "Operational Mourning and its Role in Conjoint Family Therapy," Community Mental Health Journal. 1(4), 1965, pp. 339-45.
- Pearson, L. Death and Dying: Current Issues in the Treatment of the Dying Person. Cleveland: Western Reserve University, 1969.
- Pegg, P. F. and Metze, E. Death and Dying: A Quality of Life. London: Pitman, 1981.
- Piaget, J. The Language and Thought of the Child. London: Routledge and Kegan, Paul, 1959.
- Pincus, L. Death and the Family: The Importance of Mourning. New York: Pantheon Books, 1976.
- Pollack, G. H. "Mourning and Adaptation," International Journal of Psychoanalysis. 42, 1961, pp. 341-61.
- Prichard, E. R., Collard, J., Orcutt, B. A., Kutscher, A. H., Seeland, I., Lefkowitz, N. (eds.). Social Work with the Dying Patient and the Family. New York: Columbia University Press, 1977.
- Rahe, R., McKean, J. and Arthur, R. J. "A Longitudinal Study of Life Change and Illness Patterns," Journal of Psychosomatic Research, 10, 1967.
- Rahe, R., Meyer, M., et al. "Social Stress and Illness Onset," Journal of Psychosomatic Research, 8, 1964, pp. 35-43.
- Rapoport, L. "Crisis Intervention as a Mode of Brief Treatment," Roberts, R. W., and Nee, R. H. (eds.). Theories of Social Casework. Chicago: University of Chicago Press, 1970.
- Rees, D. W. and Lutkins, S. "Mortality of Bereavement," British Medical Journal. 4, 1967, pp. 13-16.

- Reimer, J. Jewish Reflections on Death. New York: Schocken Books, 1974.
- Renneker, R. E. "Countertransference Reaction to Cancer," Psychosomatic Medicine. 19, 1957, pp. 409-18.
- Report of the Pilot Project, January 1975-1977, Palliative Care Service, Royal Victoria Hospital, McGill University, October 1976.
- Resnick, H. L. P., Rubeu, H. L. (eds.). Emergency Psychiatric Care: The Management of Mental Health Crisis. Bowie M.D.: Charles Press, 1975.
- Rochlin, G. Griefs and Discontents: The Forces of Change. Boston: Little Brown, 1967.
- Rosenblatt, P. C., Jackson, D. A., and Walsh, R. P. "Coping with Anger and Aggression in Mourning," Omega. 3(4), November 1972, pp. 283-91.
- Rosenthal, J. "Psychotherapy for the Dying," American Journal of Psychotherapy. 11, 1957, pp. 626-33.
- Rosenthal, H. R. "The Fear of Death as an Indispensable Factor in Psychotherapy," American Journal of Psychotherapy. 17, 1963, pp. 619-630.
- Sartre, J. P. Existential Psychoanalysis. New York: Philosophical Library, 1969.
- _____. Existentialism and Human Emotions. New York: Philosophical Library, 1957.
- Saunders, C. (ed.). The Management of Malignant Disease. London: Edward Arnold, 1978.
- _____. Care of Dying. Nursing Times Publications Section, 2nd Edition, 1976.
- Schnaper, N. et al. Management of the Dying Patient and His Family. New York: M.S.S. Information Corporation, 1974.
- Schneiderman, G. Coping with Death in the Family. Toronto: Chimo Publishing, 1979.
- Schneidman, E. S. "Orientations Toward Death: A Vital Aspect of the Study of Lives," International Journal of Psychiatry. 2, 1966, pp. 167-90.
- Schoenberg, B. "Management of the Dying Patient," Schoenberg, B., Carr, A., Peretz, D., and Kutscher, A. (eds.). Loss and Grief: Psychological Management in Medical Practice. New York: Columbia University Press, 1970.

- Schulz, R. The Psychology of Death, Dying and Bereavement. Reading, Massachusetts: Addison-Wesley Publishing Company, 1978.
- Scott, F. G. and Brewer, R. M. Confrontations of Death. Cornwallis: Continuing Education Publications, 1971.
- Seligman, M. Helplessness: On Depression, Development and Death. San Francisco: W. H. Freeman, 1975.
- Shneidman, E. S. Death: Current Perspectives. Palo Alto: Mayfield Publishing Co., 1976.
- _____. Deaths of Man. New York: Quadrangle, 1973.
- Shoor, M. and Speed, M. H. "Delinquency as a Manifestation of the Mourning Process," Psychiatric Quarterly. 37, 1963, pp. 540-58.
- _____. "Death, Delinquency and the Mourning Process," Psychiatric Quarterly, 36, 1963, pp. 540-558.
- Simpson, M. A. The Facts of Death. New Jersey: Spectrum/Prentice-Hall, 1979.
- Sobel, H. V. Behaviour Therapy in Terminal Care: A Humanistic Approach. Cambridge, Massachusetts: Ballinger, 1981.
- Solzhenitsyn, A. Cancer Ward. New York: Bantam, 1969.
- Spero, M. H. "Confronting Death and the Concept of Life Review: The Talmudic Approach," Omega. 12(1), 1981, pp. 37-43.
- Spiegel, Y. The Grief Process: Analysis and Counselling. Nashville: Parthenon Press, 1977.
- Steinfels, P., Veatch, R. M. Hastings Center Report: Death Inside Out. New York: Harper and Row, 1975.
- Steinzor, B. "Death and the Construction of Reality: A Revisit to the Literature from 1960," Omega. 9(2), 1978, pp. 97-124.
- Stern, K., Williams, G. W., and Prades, M. "Grief Reactions in Later Life," American Journal of Psychiatry. 108, October 1951, pp. 289-93.
- Strauss, A. L. Chronic Illness and the Quality of Life. St. Louis, C.V. Mosby, 1975.
- Sudnow, D. Passing On: The Social Organization of Dying. Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1967.
- Switzer, D. K. The Dynamics of Grief: Its Source, Pain and Healing. Nashville: Abingdon Press, 1970.

- Tolstoy, L. The Death of Ivan Illyich. New York: New American Library, 1960.
- Tomm, K. "One Perspective on the Milan Systemic Approach: Part I Overview of Development, Theory and Practice," Journal of Marital and Family Therapy. 10(2), 1984, pp. 113-128.
- Toynbee, A., Koestler, A. et al. Life After Death. London: Weidenfill and Nicolson, 1976.
- Toynbee, A. et al. Man's Concern with Death. London: Hodder and Stoughton, 1968.
- Van Gennep, A. The Rites of Passage. Chicago: University of Chicago Press, 1961.
- Watzlawick, P., Beavin, J. H., Jackson, D. D. Pragmatics of Human Communication. New York: Norton, 1967.
- Weisman, A. D. On Death and Dying: A Psychiatric Study of Terminality. New York: Behavioural Publications, 1972.
- _____. The Realization of Death. New York: Jason Aronson, 1974.
- Weisman, A. D. and Hackett, T. P. "Predilection to Death: Death and Dying as a Psychiatric Problem," Psychosomatic Medicine, 23, 1961, pp. 232-36.
- Wilkes, E. The Dying Patient: The Medical Management of Incurable and Terminal Illness. New Jersey: George A. Bogden and Son, 1982.
- _____. The Dying Patient: The Medical Management of Incurable and Terminal Illness. New Jersey: George A. Bogden and Son, 1982.
- Wolff, K. "Personality Type and Reaction Toward Aging and Death: A Clinical Study," Geriatrics. 21(8), 1966, pp. 189-192.
- _____. "Helping Elderly Patients Face the Fear of Death," Hospital Community Psychiatry. 18, 1967, pp. 142-44.
- Woodruff, D. S. and Birren, J. E. Aging. New York: O. Van Nostrand Company, 1975.
- Wylie, B. J. Beginnings: A Book for Widows. McClelland and Stewart, 1977.
- Yalom, I. D. Existential Psychotherapy. New York: Basic Books, 1980.
- Zeligs, R. "Children's Attitudes Towards Death," Mental Hygiene. 51, 1967, pp. 393-96.