Family focused grief therapy

The role of the family in preventive and therapeutic bereavement care

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Many families are intimately involved in looking after their dying relatives and mourning their loss. In a palliative setting, a family-centred model of care can not only optimise the practical support for the dying person but also the bereavement outcome, by encouraging family members to interact as a supportive group. Family focused grief therapy is founded on the proven relationship between family functioning and the psychosocial wellbeing of its members. Arising from a decade of research, this model offers a new emphasis on shared family grieving as a pathway to adjusting to death.

As we share our grief, we not only express thoughts and feelings about the loss but also seek the understanding of others[1]. Shared mourning can heal powerfully by providing the most favourable conditions for the parallel processes of grieving and adaptation. For most people the best environment is likely to be their family, both because of the members' intimate knowledge of the deceased and their motivation as a social group to help the primary mourners. But, alas, for some the family will inhibit adaptive grieving because its own functioning is impaired[2].

Supporting a grieving family introduces a paradigm shift for those trained in a model of individually-focused bereavement care[3]. Yet the family, despite variations in its form, values, mobility, cultural ethos and the position of its members across the life cycle, remains the primary source of support for the dying and usually contains those most affected by later bereavement. Family focused grief therapy (FFGT) was therefore developed within hospice care as an empirically derived model targeting the family as the most naturally occurring social group for the bereaved[4].

THE FFGT MODEL

The FFGT programme[4] is brief, focused and time-limited, usually extending flexibly across 6 to 18 months. It aims to enhance the functioning of the family by exploring their cohesiveness, communication of thoughts and feelings, and resolution of conflict. As grief is shared, its impact on how the family operates is observed. Improving the group's way of relating together nurtures family-as-a-whole grieving and promotes an adaptive outcome for all concerned.

A preventive model based on the hospice ideal of family-centred care

In hospice or palliative care, the dominant mode of medical provision for the dying today, the emphasis is on comprehensive support rather than cure and this naturally extends to the carers, most commonly the family, allowing for the possibility of continuity of care. The principal caregiver has been shown to be the spouse in 70% of cases, children (daughters and daughters-in-law predominate) in 20%, while less than 10% are friends or more distant relatives[5,6]. When bereavement support can be offered alongside palliative care, such early intervention can be thought of as preventive bereavement care[7].

While the dying family member is the primary focus of palliative care, the challenge has been to integrate emotional support for the family with the practical care. From the medical viewpoint, the physical and social needs of the patient and family have dominated; for bereavement care, adjustment and coping need to be attended to psychologically and spiritually. Over recent decades attachment theory, the nature of interpersonal bonds and the more recent emphasis on continuing bonds[8,9] have all improved our understanding of the process of grieving. Relationships are at the root of our experience of mourning: first and foremost, the quality of our relationships impacts on the outcome. How well each family communicates, shares, supports its members, operates as a team and tolerates difference of opinion is the essence of its functioning.

The operation of the model

A typology of family functioning (classification of types of families based on how they function) during palliative care and bereavement, developed using the Family Environment Scale[10], categorises families into well-functioning, intermediate and dysfunctional classes[11-14]. Members of well-functioning families have been observed to have significantly lower levels of psychological and social difficulties and can be expected to have the wherewithal to grieve adaptively. Scarce clinical resources can therefore be directed towards the other two classes of families at relatively greater risk.

Dysfunctional and intermediate families are selected by screening within a clinical programme using the short form of the Family Relationships Index (FRI)[10], a 12-item questionnaire completed by each family member independently. Families are never labelled, as the screening process is not itself diagnostic but rather has rules

EDITOR'S NOTE

The family exists as a source of support to its members yet there are few counsellors who attempt to support families as opposed to individuals. Even in hospices, where the family is widely recognised as the unit of care, most of the bereavement counselling is one-to-one. Kissane and his colleagues in Melbourne, Australia, take a different view and this paper gives a concise account of their methods which are described in more detail in their important book, *Family Focused Grief Therapy*. We review the book in this issue, p5, and the results of an ongoing random-allocation study of this therapy are eagerly awaited. *CMP*

that identify those at greater risk. Therefore, when the family is invited to meet a therapist, the reason given is that as a palliative care service 'we believe it is important to support families in the care of their dying family member'.

Each therapy session lasts 90 minutes, and the whole course of 4 – 8 sessions can be divided into three sequential phases:

- **Assessment** (one/two weekly sessions) involving identification of relevant issues or concerns for the family and negotiation of a therapeutic plan to work on these;
- **Intervention** (typically two/four fortnightly or monthly sessions), focusing on the agreed concerns;
- **Termination** (one or two sessions at two- or three-month intervals) consolidating and ending the therapy.

The frequency and total number of sessions are adapted to each family's context and needs. Although developed for the families of adult cancer sufferers, adolescents, children and grandchildren automatically become involved in FFGT, so this seems to be a model that can be generalised.

THE COURSE OF FFGT

When setting up the initial family session[4], the leading question is who should attend? A very open and welcoming attitude prevails, depending primarily on the patient and relatives to select attendees. Systemic theory reassures us that change induced in one part of a system will eventually influence other parts reciprocally[15-17]. Nonetheless, co-residents and all involved with the care of the ill person are invited (together with the patient), the rationale being to help the dying. In practice, active telephoning may be needed to draw reticent members into attending.

During assessment, as the story of illness is heard, the therapist gathers data about how the family operates, observing communication, sources of support, emotional involvement, allocation of roles and the capacity to resolve differences. A detailed family tree helps everyone to review earlier losses and recognise particular patterns of relationship that may repeat from one generation to the next. Families can take responsibility for behaviours more easily once a pattern of this sort is understood. Family functioning is focused on three domains that appear central: promoting cohesiveness, expression of thoughts and feelings, and effective conflict management[4].

Towards the end of the assessment phase, the therapist's goal is to help the family to agree about any issues or concerns central to their overall wellbeing. At the same time, it is most important to identify strengths and assets so that the therapist achieves a balanced and non-critical stance towards the family. It is then usually possible to negotiate a relevant number of further meetings to support the family and help them work on their designated concerns.

No matter what the therapy goals, common themes emerge. The imminent death of the ill relative is obviously central. As questions from family members lead into a discussion of prognosis, anticipatory grief can find a voice. Members are encouraged to ventilate this grief, and also to exploit creatively the time remaining with their dying relative. Bidding farewell is a poignant experience when faced courageously by all involved, offering the possibility of concluding unfinished business and acknowledging and celebrating each member's contribution to the family.

The sessions are also used for discussing care plans and solving practical problems. When a dying person is anxious about being a burden, their spouse and children can reassure them by expressing gratitude for all they have received. Existential uncertainty and any moments of helplessness in family members can be countered by the therapist's emotional caring. As the family begins to work as a team, they become more intimate. Where there is conflict, it is important to explore the issues involved. It is especially helpful here to recognise entrenched, maladaptive 'scripts'[18], in which blaming, avoidant and denying behaviours hamper effective functioning. Not all tensions can be released: indeed, some difference is the essence of diversity in nature and requires tolerance and mutual respect. At the same time, forgiveness for past neglect of the feelings of others is central[19].

After the death

Where a good bond has been established, the family usually welcomes the continued support of the therapist after the death. The greater family cohesion and open communication that have been developed usually promote mutual comfort for the members in their grief.

At this stage, particular challenges can be presented by alcohol and other substance abuse, physical and mental illness, the occurrence of cancers in other members, prominent cultural differences, and issues that arise from the blending of families through re-marriage. Nonetheless, the therapist's continued support for the family in guiding the members to act effectively as a group helps the grief process[4].

Once the family can acknowledge that progress has been made, sessions can become less frequent. Finally a point is reached when a plan should be made to end therapy. The therapist may need to pay explicit attention to any residual worries or unfinished business and if these cannot be dealt with over the final sessions, it may be necessary to arrange for another intervention, such as individual therapy for one or more members. The family members are encouraged to go on monitoring their functioning, and reminded that their old patterns can easily re-emerge and will need continued and systematic attention. Finally everyone is invited to celebrate their successful work together, and the resulting exchange of feelings about finishing therapy serves to model a healthy adaptation to loss.

THE THERAPIST'S ROLE

Training for therapists is very important so that as facilitators they can remain neutral amid the varied opinions, generate hypotheses about relationship issues, and ask questions in both a circular manner to collect data and strategically to guide members to a constructive resolution of problems[20]. Remaining attuned and empathic to several people in a room requires considerable effort, and experience beyond that employed in individual grief counselling. However, FFGT harnesses members as helpers and supporters of one another in a more powerful manner than one-to-one therapy can and, moreover, the novice can be trained as a co-therapist alongside a more experienced family counsellor

While the community focus of palliative care in Australia strives to support the family in its home, not all meetings can be safely conducted there. Some behaviour is better contained when people meet on unfamiliar or neutral territory. For instance, for families for whom conflict is a problem or where splits have occurred in the past and old patterns are likely to recur, the hospice or outpatient office is preferable. Wise planning is necessary in setting up any session: factors to consider are location, who is expected, and what focus is needed at this stage of the family's work together.

Therapists need insight into the range of challenging issues that arise in families. However, unless the therapist can sensitively clarify that such concerns exist for a family, and get their agreement on this, it is unlikely that a continuing rationale for further meetings will be found. In contrast with individual counselling, families are much less inclined to seek out assistance

because a collective wisdom has not been formed about their needs. In the first instance it is the therapist who must have this insight and take responsibility for guiding the family towards a new, shared understanding.

Considerable experience is also needed to accurately identify and affirm the family's strengths so that the therapist does not appear unduly critical and in the process harm the family, and so that the members feel understood and supported. These affirmations can be woven into any summary of agreed issues, and even highlighted as a potential pathway towards resolution. When this is not done successfully, the therapist is often unable to persuade the family to agree to a realistic agenda for their therapy.

The therapist must consider what is achievable for any family. It may not be possible to heal long-standing conflict and resentment; therapists need to balance any desire to rescue with identification of achievable and, if needs be, modest goals for families with a long-term history of dysfunction. This is a pragmatic reality, though the experience of FFGT may prepare some members for future psychological work.

The therapeutic processes of FFGT involve the parallel enhancement of family functioning – such that communication, cohesion and conflict resolution improve – and the promotion of shared grief. This approach nurtures relationships among the living while the deceased is mourned appropriately.

SERVICE IMPLICATIONS

A recent controlled trial comparing bereavement care in a palliative setting with that in a conventional hospital failed to demonstrate any improvement in bereavement outcome[21]. This highlights the challenge for the hospice to successfully integrate family care into its practices. FFGT offers an approach that allows supportive therapy to begin before the patient's death and sustains continuity of care throughout bereavement. Its combined focus on both family functioning and mourning integrates the dual processes of grieving alongside adaptation, a coping model that Stroebe and Schut have emphasised[22]. FFGT can be used by all health practitioners trained in family therapy, be they social workers, psychologists, psychiatrists, physicians or general practitioners.

The substantial experience acquired in conducting a randomised trial of FFGT has been described in our recent book[4] and the stories of the many families therein demonstrate the feasibility and value of the therapy. The family is inextricably drawn into care provision of the dying and serves in many instances as the naturally occurring group for continued bereavement support. FFGT is a most promising approach to accomplish this goal. BC

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EVENTS IN 2003

Managing sensitive research. Speakers: Anne Corden, Liz Rolls. 7 May. London; **Spirituality and bereavement.** Speaker: Kiri Walsh. 6 November. Manchester. Bereavement Research Forum symposia. ☎ 02392 250001; elaine.davenport@rowanshospice.co.uk

Personal traumas. 10th annual international conference of the Manchester Area Bereavement Forum. Speakers: Jack Morgan, Jim Kuykendall. 5 September. Manchester, UK. Contact Angela Trinder, The Grief Centre, 362 Manchester Road, Manchester M43 6QX; ☎ 0161 371 8860.

Our children – loss in schools – time to listen. Lost for Words 2nd international conference. Speakers: Linda Goldman, Louise Rowling, Peta Hemmings. 8 October. Hull, UK. ☎ 01482 613390; alison.moore@hullcc.gov.uk

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Bereavement and how it fits into primary care counselling practice. Masterclass with Philippa Weitz. 11 June. London. Contact Mole Conferences ☎ 01273 242634; www.mole-conferences.com

Bereavement: challenging cases. 13 May. **SeeSaw Child Bereavement – sharing the journey.** Workshops. 4 June. **Supervision in palliative and bereavement care.** Two-day course with Marilyn Relf, Kathy Warburton. 1-2 July. **Update: grief and bereavement.** 9 July, 15 October. Oxford, UK. Sir Michael Sobell House Study Centre. ☎ 01865 225886; ssc@orh.nhs.uk