

# GRIEF THERAPY AND FAMILY SYSTEMS

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In the past few years, there has arisen an increasing interest in bereavement in general and grief therapy in particular. Books and several articles have been published concerning bereavement and various ways of coping with it (Vollman, 1971; Volkan, 1971; Parkes, 1975, 1983; Worden, 1984). Since most significant losses occur within the context of a family unit it has often been found important, as Murray Bowden (1978) indicated, to consider the impact of death on the entire system. The purpose of this paper is to present a strategic hypnotherapy approach that has been used successfully with grief symptomology based upon a family dynamics perspective.

## **Basic Orientation**

When a love tie is severed, a reaction, emotional and behavioural, is set in train, which we call grief. We experience the greatest reaction when we experience bereavement. Loss of a loved person is one of the most intensely painful experiences any human being can suffer (Bowlby, 1980). Loss imposes a disruption of taken-for-granted reality, an attenuation of meaning and a threat to identity. The initial reactions of shock, disbelief, hearing and seeing the dead person and subsequent feelings of anger, disorganization and meaninglessness can readily be understood within this framework.

Bereavement can have detrimental effects upon physical and mental health (C.M. Parkes, 1975). Illnesses are usually characterized by the discomfort and the disturbance of function that they produce. Grief may not always produce physical pain but is very unpleasant and it usually disturbs function. When grief is severe the bereaved person may be disabled for weeks. On the whole however, grief resembles a physical injury more closely than any other type of illness. The "loss" may be compared to a physical "blow" which numbs; and at least the "wound" usually gradually heals. Yet abnormal forms may arise where sometimes it seems that the outcome may be fatal (C.M. Parkes, 1975). Hence in many respects grief can be regarded as an illness. But it can also bring strength, as the experience of grieving can affirm and bring maturity to those who can muster an open and positive attitude towards it.

Most empirical studies have focused on individual experiences of grieving and mourning. There is useful evidence relating to factors which are likely to influence a family's reaction to the death of one of their members (Smith, 1982). It has been noted that difficulties for the whole bereaving family are likely to revolve around communication breakdown, social isolation of members, redistribution of roles and personal confusion. The uncertainties and conflicting demands of the terminal phase and death are likely to put particular pressures on family relationships and functioning. Difficulties in communication may arise because the normal network of interaction has been disrupted. Vollman et al. (1971) found that families having open and effective communication systems which facilitated the expression and sharing of sadness, anger, guilt and so on are more likely to make a good adjustment following bereavement, than other families with a pattern of denial or suppression of feelings.

A death can trigger intense feelings, hence a context in which these feelings can be experienced, identified and brought to completion is important (Worden, 1984). Murray Bowen (1978) suggest that knowledge of the total family configuration, the functioning position of the dying person in the family, and the overall level of life adaptation are important for anyone who attempts to help a family before, during and after death. The loss of a significant person in the family group can often disturb the homeostatic balance of the unit and cause the family to feel pain and seek help.

The family is an interactional unit in which all members influence each other. But family dynamics can hinder adequate grieving. Hence it is often not sufficient to treat each individual in relationship to the deceased and to deal with him or her grief without relating it to the total family network.

### **Therapeutic Intervention**

In grief therapy the intervention focuses on the reactivation of the mourning process (Worden, 1984). The nature of the recovery process has often been aptly characterized by more than one bereaved person asserting that: "You don't get over it; you get used to it." C.M. Parkes and R.S. Weiss (1983) state that those who recover from bereavement do not return to being the same people they had been before their loved ones' death. Nor do they forget the past and start a new life. Rather, they recognize that change has taken place, accept it, examine how their basic assumptions about themselves and their world must be changed and go from there. Meanwhile each of these steps requires courage, effort and time. Worden (1984) has formulated four main tasks of grieving: first, to accept the reality of the loss; second, to experience the pain of grief; third, to adjust to an

environment in which the deceased is missing; and fourth, to withdraw emotional energy and reinvest it in another relationship. Obviously recovery from bereavement requires intellectual recognition, emotional acceptance, and a new identity appropriate to the changed life situation (C.M. Parkes and R.S. Weiss, 1983).

In strategic family therapy the responsibility is on the therapist to plan a strategy to achieve the above-mentioned goals. Various methods of intervention of the strategic school have been used, following mostly however, the strategic family dynamics as understood by Madanes (1981) and Haley (1976). Different induction methods were considered (Erickson, Miller, Frankel), but an endogenic approach with multiple phases of depth level of trance has been found to be most successful. Furthermore, the works of Worden and Parkes in the area of grief therapy have been heavily drawn upon.

The first task of the therapist is to conceptualize the bereavement situation as one in which the family's ability to recognize significant roles so that family functioning could be maintained (Goldberg, 1973) depending on the importance of the tasks previously carried out by the deceased. Frequently the family ends up in a situation of bickering and conflict or with various family members withdrawing emotionally. Hence at the very beginning of the therapeutic strategy the therapist will need to sort out the real issues and the peripheral issues (Worden, 1984). There may be particular responses to loss depending on the status of the deceased as partner in social interaction. The death of a husband or a wife is likely to highlight the whole range of difficulties associated with the disruption of meaning and identity. The death of a child may raise greater, more profound anxieties about reality and meaning than about personal identity, where significant others are still available to confirm this through social interaction. Another type of disfunction which can occur after the death of a child is the break-up of the marriage and the stress that it places on the family unit. The death of a parent in its turn may disrupt those channels of communication and patterns of interaction which provide any sense of stability and enable the development of and confirmation of identity and self-esteem. Hence in order to understand the particular impact of the specific loss it is necessary to appreciate the part played by the deceased in one or more areas of reality construction, meaning and confirmation of identity.

One important reason for looking at a family system approach is that unresolved grief may not only serve as a key factor in family pathology but may also contribute to pathological relationships across generations. Postponed mourning related to one's family of origin impedes experiencing emotional loss and separation within the current family (Spark and

Browdy, 1972). In assessing grief and family systems three main areas have to be attended to (Worden, 1984): first, the functional position or role of the deceased. Addition or loss of a family member can result in disequilibrium. Through death the family can be deprived of an important role and another member might be sought out to fill the vacancy. Children also play important roles in the family, and their deaths upset the family balance. Death of either parent when the family is young can have long range effects. It not only disturbs emotional equilibrium, but also removes the function of the breadwinner or the mother when these functions are most important. Secondly, one needs to assess the emotional integration of the bereaving family, as some families are well whereas others are less integrated. Affective expression is so important in the mourning process. Thirdly, the therapist needs to assess how specific families facilitate or hinder emotional expression. Thus one seeks to understand the values families place on emotions and the kinds of communication patterns that give a person permission to express feelings. Families which conspire to keep feelings down or at a distance may ultimately keep the individual from an adequate resolution of grief.

After the assessment and the function of the systems have been formulated, the therapist then arranges an individual session with the symptomatic members of the bereaving family in order to decide upon the best method of hypnotic induction. First, of course, the use of hypnotherapy must be explained to the individual and the family in such a manner as to reduce any anxiety they may have about the procedure. An endogenic approach with multiple phases of depth level of trance has been found to be most successful. When the individual member of the family with whom the therapist is working has been able to achieve some level of trance, the therapist may make use of direct suggestion for facilitating the four main tasks of grieving as described above. Concurrently, the family should be seen together by the therapist. In these sessions, the theme centres around the grief process. This process should lead to the recognition and acceptance of the loss. The deceased are not forgotten but they become located in the past while their memory is incorporated into the present reality.

Many people with adequate personnel and social resources will be able to recognize the reality of loss, express their grief and face the confusion and disruption of their social world. However, for various reasons, some will avoid or side-step this painful and confusing process. Some people seek help instantly and the therapist will need to allow the initial period of numbness without attempting any active work towards the recognition of loss. Within the context of the family dynamics, the therapist who worked with the bereaved to encourage the acceptance of loss now sees the bereaved

led into acute sadness and apparent despair. This is a very delicate time and can be somewhat utilized by the therapist to enable the bereaved to 'let go' of the deceased within the comforting support of the family unit.

It is important to recognize here that the therapist is acting as a 'bridge' or temporary 'stand in' until the bereaved regains sufficient confidence to open up interaction with other people. Furthermore, one of the goals of grief therapy is not to become a replacement for the person who has died. Rather, gradually with prompting and support from the therapist, the bereaved will begin again to renew old relationships and make new ones. It would appear from studies conducted by Goldberg (1973) that families with good communications system as well as prior equitable role allocation respond more adaptively to the crises of death. Cohen et al. (1977) also concluded that the more family members were able to communicate with one another to share in decision-making, the greater the likelihood of an effective adjustment during the post-death period.

### **Case Examples**

For those whose expressions of grief are blocked or discouraged by others, those who have no time to grieve because of other demands, or who cannot give up their relationships with the deceased because of 'unfinished business', an already insecure sense of identity and self-esteem, or dearth of alternative ways of social interaction, grief work may be avoided or overlooked. If this happens it is likely that disengagement from the deceased will not be fully accomplished. In such case the ability to develop new relationships and to engage in the social construction of a reality which recognizes the absence of the lost person will be difficult to attain.

This was the case of a 34-year-old mother who reported unresolved grief over the death of her 5-year-old son who died of leukemia almost 5 years earlier. She lived with her husband and another son who was then 6 years of age. The second son was only 19 months old when his older brother died.

In the initial interview with the mother on her own, it was determined that due to unresolved grief she was still suffering from enormous psychological pain over the loss of her child, (five years earlier), to the extent that she expressed the thought that she would perhaps have preferred that the son had never been born to her. From an anxiety scale administered to the patient it was revealed that she suffered not only from psychological symptoms of anxiety such as nervous tension, irritability, insomnia, fatigue and depression, but also physical ones such as dizziness, palpitations, chest pains, lack of appetite and short breath. It also became obvious that some marital tension existed within the family.

The patient came from an extended family whose members were very supportive of each other. She was seen concurrently with her husband and son as well as her sister.

The individual sessions with the mother revealed that her prolonged and extreme mourning pointed to an unwillingness to accept the finality of her child's loss, and hence was unwilling to disengage her from him. The therapist explained to her that if she were to work through her pain she would need to use her mind creatively to help with problem, and that in order to do that she would need to be relaxed and listen to what the therapist would tell her. The method of induction chosen was an endogenous technique with multiple phases of depth level of trance, in which she was asked to concentrate on her own breathing until her breathing became shallower and her toes began to deviate. She was also given suggestions for eye closure (Kroger, 1977). Since she was a co-operative person with quite a desire to please, it was decided to use direct suggestion. She was seen four times over five weeks and told under hypnosis not to be afraid to talk about her grief and pain, and that there was no need for her to continue to try to help her family, especially her husband, to avoid marital problems because the therapist will do that. If she wanted to help the therapist to help sustain her marriage, she could do so by becoming more assertive and owning up, especially in the presence of her husband, to her anger, sense of guilt and sadness about her child's death. The therapist identified with such feelings and encouraged their expression while he provided some sense of safety and control which have previously been absent.

The patient's husband and her sister were helped to understand that trust in each other and willingness to show their vulnerability were required to offer comfort and understanding. The therapist also helped them consider the nature of relationships within the family and the way in which fears and mistrust can develop. It was explained to the whole family that difficulties in communication appeared to have arisen because through the death of the child the normal network of interaction had been disrupted. The therapist continued to encourage the expression of feelings, acting as a communication link because before coming to therapy the mother had almost become isolated. Meanwhile the therapist sought to guide the clarification of the existing problems and consideration of solution, as such task can often be more readily achieved by someone who is outside the immediate family circle.

Whatever the relationship of the bereaved to the deceased, there appears to be general agreement that any successful adjustment to loss can only be accomplished if those who are left carry out what has been termed their 'grief work' (Volkan, 1975). Gradually the patient came around to the most important phase of such 'work' namely, the disengagement from the

relationship and interaction with her deceased son. This was mostly brought about by repeatedly asking the patient under hypnosis to look at a photograph of her deceased child as she visualized herself saying "goodbye" to him. This particular exercise allowed the bereaved mother to tolerate the pain associated with recognizing and accepting the reality of her loss. Follow up at the three and six months intervals revealed that the patient's symptoms were greatly reduced and she was adjusting well to the loss. She also showed inclination to reinvest the withdrawn emotional energy from the deceased in the second son who for the most part was in the emotional care of her sister. The parents were still together and showed interest to seek marital therapy in due time. Attention was also being paid to avoid putting pressure on the remaining child to take over the affective function of his dead sibling.

## CASE II

A 48 year-old widow was referred to therapy by her family because of her reluctance to make any attempt to adjust to the loss of her husband twenty-one months after his death. The widow resisted any emotional acceptance of her husband's loss, nor was she ready to accept a new identity appropriate to her changed life situation. Her 18 year-old daughter related that her mother had very poor relationships with any one outside the immediate family circle since her father died. She spent most of the day cleaning the house. The therapist conceptualized the widow's behaviour as being one of total emotional dependence on her husband prior to his death.

For widows and widowers to engage in their activities without additional anxiety, they must continue to feel that the world makes sense. This did not appear so for the patient who even refused at first to merely attempt to visualize her life without her partner. In the meantime she was becoming more and more dependent on her surviving aging mother. The therapist explained that the widow needed to work towards emotional acceptance of her loss before she could hope for some relief of her symptoms. She was told that what could facilitate such acceptance was repeated confrontation with every element of the loss until the intensity of distress would be diminished to the point where it became tolerable and the pleasure of recollection began to outweigh the pain.

During the first two sessions the therapist explained to the widow that she owed it to herself and no-one else to learn how to relax and let go. The method of induction used was the endogenic method. She was given suggestion for eye closure and for trance deepening.

The bereaved will begin to show their acceptance of loss when they talk about the deceased in terms of death and their aloneness. At one stage the

widow remarked that "the house seemed so empty". Later the therapist encouraged her under hypnosis to develop an "account" or an explanation of how her husband's death occurred. Obviously an adequate account is not sufficient for recovery from bereavement, but it is necessary because without an "account" that settles the question of "why" the bereaved can never relax their vigilance against the threat of new loss.

The widow's mother and her three daughters (18, 21 and 23 years of age respectively, all three of which were still at home), were seen concurrently with her. The therapist explained to them that if the patient were to arrive at an emotional acceptance of her loss, she had to feel no longer in need of avoiding reminders of her husband, for fear of being flooded by grief, pain and remorse. One of the goals of the therapist was to utilize the other family members to help the widow reach a certain amount of emotional acceptance by way of repeated confrontation with every element of the loss until the intensity of distress could start to diminish. Furthermore, the therapist sought to help the family develop an area of shared understanding as a basis for continuing interaction. Encouraging the expression of feelings among family members is an important task of grief therapy with family systems.

At one stage during an individual session the therapist asked the widow, while under hypnosis, whether she had ever contemplated getting angry at anyone. She admitted that she often felt angry at people but was always afraid to express such feelings. At this point the therapist suggested that she may try to look back and see if she could remember some negative aspect of her late husband's character. She said she could and added: "At the moment I actually feel so angry at my husband who I feel had always treated me as if I were one of his daughters. He was always making decisions for me. And now I feel so empty!". The therapist encouraged such expression of feelings and suggested that it could be very beneficial for her if she could look back on the memory of her husband in perspective, considering not only his positive but also his negative characteristics.

As the loss became a reality and the pain of being alone and facing each day without her deceased husband began to be experienced, the widow was helped to view her life in this new situation, assisting her to work towards a new identity. A female co-therapist was also engaged to see her in individual sessions. Both therapists continued to encourage the recognition and acceptance of the fact that the deceased was dead and lost to our world of everyday interaction and meanings. It was also explained to the family that they needed to maintain an attitude of concern and willingness to be with her in sympathizing with the pain and sorrow which this involved.

The sessions took place over a period of four months. A follow-up at the three and six month intervals indicated that the process of recovery was



well on its way.

### CASE III

A 48 year-old man was referred to therapy by his factory personnel officer on the grounds of severe anxiety and depression. Medical treatment had failed. Absenteeism from work was also becoming a problem. During the first session he revealed that he had lost an 18 year-old son in a car accident a year earlier. He claimed that he could somehow cope with the bereavement process, but what certainly made him feel very depressed was his wife's morbid reaction to their son's loss. He was told that there were several things he could do to help his wife but first of all the therapist suggested that he could learn some relaxation techniques which would help him relieve his anxiety. He was quite co-operative and showed readiness to do all that could be helpful to relieve his tension. The endogenic induction technique was used. At the end of the second individual session it was suggested to him to invite his wife to attend the next session with him. The therapeutic hypothesis was that his depressive emotional state was dependent on his wife's unresolved grief over their son's death. Meanwhile he was congratulated for learning to relax so well and he was told that his wife needed his help to be able to adjust to the situation.

Most people are able to cope with reactions of grief and work through the four tasks of grieving on their own, seeing grief to its conclusion, bearing in mind that grieving is a natural process as Sigmund Freud had suggested. However, in the first session with the couple it was revealed that the wife had done very little proper grieving over the past twelve months since the accidental death of her son. The couple were seen along with a female co-therapist. Basic human comfort and support were offered to promote, especially on the wife's part, the expression of grief, thus facilitating the mourning process within the family unit. The couple had several other children but none of them was able to attend any of the sessions. So wherever possible, the husband, whose symptoms had by now been greatly relieved, was used as a significant member of the family network to accommodate his wife's activity of mourning.

Individual sessions with the wife were held to help her with her 'grief work'. She was quite responsive to the endogenic induction approach. Direct suggestion was used. She was seen four times over five weeks and introduced under hypnosis to 'regrief therapy'. She was asked to visualize her dead son as he was at home until the day of the fatal accident. This technique helped inhibit the anxiety state that prevailed earlier whenever the image of her son was recalled. Her ability to relax deeply helped her to acquire a fair amount of desensitization in this direction.

The couple were very supportive of each other. This highly promoted the resolution of grief within the family unity. As the therapists gave the couple the chance to share their feelings with someone who was not shocked nor alarmed, they directed the bereaved couple to express their feelings of anger (and perhaps guilt) because of 'unfinished business' with their deceased son. Halfway through the last session the couple spoke of the possibility of going away together on a short holiday. They were encouraged to do so.

Follow-up at the three and eight month intervals revealed that there were no serious obstacles to the mourning process towards their recovery from bereavement.

### **Summary**

There are various important steps in the proposed recovery process and recovery from bereavement. They are summarized as follows:

1. The family is interviewed so that the therapist might form an hypothesis concerning the nature of the bereavement.
2. After the hypothesis has been conceptualized, the individual and other members of the bereaving family are seen in concurrent sessions.
3. In the sessions with individual members presenting acute symptoms of bereavement, the therapist must find a hypnotic induction method that takes into account the individual's stage of recovery and ability to cope with the different tasks of the grief process.
4. After the individual is successfully induced into hypnotic trance, the therapist either uses direct suggestion to facilitate resolution of grief or subliminal suggestion to substitute a less severe behaviour for the symptomatic behaviour.
5. In the sessions with the family the individual's stage of recovery and symptomatic behaviour are explained.
6. If marital problems surface, they are not dealt with until there is an improvement in the individual's recovery.
7. Ultimately the recovery process and recovery from bereavement requires intellectual recognition, emotional acceptance, and a new identity appropriate to the changed life situation.

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