Family grief therapy
A vital model in oncology, palliative care and bereavement

Tammy A. Schuler, Talia I. Zaider and David W. Kissane

Life events are formed by inescapable experiences that bring some degree of challenge, change or loss and need for adaptation to those affected. The most natural support base in this setting can be the family. Distress and grief associated with life events, such as a life-threatening illness and bereavement, can be helpfully shared with the family, who assist with processing and making sense of the event, provide mutual support and caregiving and, eventually, help with coming to terms with the losses and moving forward with life (Kissane & Bloch, 1994).

When a family’s functioning is optimal, their support generally points towards an adaptive process of adjustment. Openness of communication of thoughts and feelings, family cohesiveness, and the constructive resolution of differences of opinion are the hallmarks of a well-functioning family. Such robustness is then protective against the stress of the life event (Kissane, Bloch, McKenzie, McDowall, & Nitzan, 1998). It is when the family’s relational functioning is more limited that they prove less able to reach an adaptive outcome.

There have been few trials showing the benefits of family-centered care (Goldstein, Alter, & Axelrod, 1996; Kissane et al., 2006), but a long history of literature hinting at its importance. Early case reports suggested that family work was key in overcoming chronic and complicated grief after individually directed therapy had failed (Lieberman, 1978). In contrast, premature family intervention immediately following motor vehicle deaths (Williams & Polak, 1979) and brief pediatric family therapy following a parent’s death (Black & Urbanowicz, 1987) did not sustain benefits. A randomised trial of parents with HIV failed to find differences between their bereaved and non-bereaved adolescents at two-year follow-up (Rotheram-Borus, Stein, & Lin, 2001; Rotheram-Borus, Weiss, Alber, & Lester, 2005). Challenges exist in the nature, quality, dose and timing of family interventions with the bereaved. Fortunately, promise has emerged with our preventive model for “at-
Cancer is socially constructed as a death threat because it constitutes the pathway toward dying for nearly one-quarter of the community.

The effect of cancer on the family

Distress and existential challenge

Cancer is socially constructed as a death threat because it constitutes the pathway toward dying for nearly one-quarter of the community (Centers for Disease Control and Prevention, 2012). Because of the considerable existential challenges that accompany the cancer journey, many call into question the very purpose of life. Fear of cancer’s spread throughout the body, the uncertainty associated with its prognosis, the loneliness of the journey for each individual afflicted, the potential harshness of its treatment (such as disfigurement and secondary morbidities), its interruption of pursuits and its spoiling of quality of life are all a part of the cancer journey to varying degrees.

Cancer therefore is responsible for much loss, change, grief and transition. Adaptive coping capacities are quickly required. Not surprisingly, cancer causes significant anxiety, depression, maladaptive adjustment and complicated grief. Estimated rates of major and minor depression range up to 50% among patients, varying by diagnostic site (Massie, 2004). Around one-third of the spouses of cancer patients have been found to be depressed, while one-quarter of adult offspring have been found to be clinically distressed (Edwards & Clarke, 2004). Distress clearly reverberates throughout the family of a patient with cancer.

The contribution of family

Families constitute both the setting where one finds suffering associated with cancer and the potential source of support that ameliorates its pain. They thus form a key environment of care provision, instrumental help and emotional support. A well-functioning family is an invaluable resource to the medically ill; a dysfunctional family can unwittingly handicap care provision and healing. Just as highly charged and critical emotionality within a family can precipitate the relapse of psychotic illnesses such as schizophrenia (Vaughn & Leff, 1976), or perpetuate the recurrence of depression (Keitner & Miller, 1990), our work has shown that the family environment contributes critically to psychosocial morbidity (e.g., depressive symptoms, the development of an anxiety disorder, problematic alcohol use) that can accompany grief (Kissane, Bloch, Dowe et al., 1996). A family-centred approach to the care of patients with cancer and their families becomes crucial if we are to successfully foster healing and protect against greater morbidity.

Impact of bereavement, grief, and complicated grief

Bereavement and grief

Bereavement, the state of loss resulting from death (Genevro, Marshall, & Miller, 2004), is a universal experience. Its association with morbidity and all-cause mortality (i.e., death due to any cause in a given population) is well-established (Elwert & Christakis, 2008; Stroebe, Schut, & Stroebe, 2007). According to the World Health Organization, 7.6 million patients died of cancer in 2005 (World Health Organization, 2007). As a function of the estimate that each patient leaves four survivors behind (Prigerson et al., 2009), it is thought that approximately 30.4 million individuals were bereaved due to cancer that year (Lichtenthal, Prigerson, & Kissane, 2010). Thus, a discussion of the implications of cancer-related bereavement and grief is integral to understanding the effect of cancer on the family system.

Though bereavement is a universal experience, the course of mourning—the process of resolving emotional distress, cognitions and behaviours that occur in response to death—is somewhat variable (Raphael, 1983). The experience and expression of grief differs across individuals, even across members of the same family. Regarding grief’s basic trajectory, emotional distress is often elevated immediately following bereavement, which initially makes it difficult to distinguish more typical distress from more pathological forms. Typical emotions that wax and wane over time are sadness, anger, guilt, anxiety, and despair (Parkes, 1998). Cognitions range from...
deliberate reminiscing to experiencing intrusive images, while behaviours such as social withdrawal or support-seeking can alternate. Physical symptoms include sleep disturbance, fatigue, anorexia, mild weight loss, numbness, restlessness, tension, tremors and pain (Lichtenthal et al., 2010). The longitudinal Yale Bereavement Study highlighted that grieving is often accompanied by a profound sense of yearning for the deceased. In general, declines in shock, yearning and sad mood were noted across a 22-month follow-up period, while anger remained low and stable (Maciejewski, Zhang, Block, & Prigerson, 2007).

As time progresses, memories of the deceased and bonds of attachment continue; however, the majority of bereaved are gradually able to adjust. They reengage in work and leisure activities, maintain and develop meaningful interpersonal relationships, and consider the future as being potentially meaningful and satisfying (Lichtenthal et al., 2010). Grief reactions may be reactivated by reminders of the deceased or anniversaries, but tend to decrease in intensity and increase in brevity. Ultimately, some 50% of bereaved individuals are truly resilient, and the majority (80%) experience minimal psychosocial complications (Bonanno et al., 2002). Clinicians want to focus on those who experience more pathological forms of grief and/or worsened psychosocial outcomes. Identifying and providing assistance to such individuals is a primary aim of family research in psycho-oncology.

**Anticipatory grief**

From diagnosis, families coping with cancer recognise that the disease may become terminal. Thus grief may begin well before the time of bereavement. More intense anticipatory grieving (or grief-related emotional distress, cognitions, and behaviours that precede the event of bereavement; Raphael, 1983) occurs with disease progression or when other forms of bad news are received (Lichtenthal et al., 2010). Though findings have been mixed, intense anticipatory grief may predict increased psychosocial distress (Levy, 1991). Adaptive communication patterns and familial cohesion may assist families in coping with anticipatory grief (Lichtenthal et al., 2010). However, maladaptive familial interaction styles may lower the ability to cope with anticipatory grief and/or decrease psychosocial adjustment (Kissane & Bloch, 1994).

**Complicated grief**

Grief becomes seriously problematic for a relative few. However, complicated grief, notably distinct from acute and/or non-complicated grief, is under consideration for inclusion in the forthcoming fifth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). Complicated grief disorder (CGD, also referred to as prolonged grief disorder) is chronic grief with an intensity that persists, rather than diminishes, past six months of bereavement (Prigerson et al., 2009). The experience includes separation distress (expressed as continued longing or yearning for the deceased person), disruptive preoccupation with thoughts and memories of the person, avoidance of reminders that the person is gone, deep and relentless sadness, self-blame, bitterness or anger in connection with the death, and an inability to gain satisfaction or joy through meaningful activities or relationships with significant others (Horowitz et al., 1997). Complicated grief connotes ongoing severe psychological distress and marked disruption of psychosocial functioning. Compared with non-complicated grief, complicated grief has been linked with poorer psychosocial (Prigerson et al., 2009), biological (O’Connor, Wellisch, Stanton, Olmstead, & Irwin, 2012), and physical health (Prigerson et al., 1997) trajectories.

**Poor outcomes associated with dysfunctional family types**

A typology of families coping with cancer, based on family members’ perception of relational functioning within the family environment, has been empirically derived using the Family Relationships Index (FRI; Moos & Moos, 1981). Five types have been identified, and are described here. Two are well-functioning with adaptive outcomes (termed supportive and conflict-resolvers), where cohesion and mutual support are high or difference of opinion is well tolerated (Kissane, Bloch, Dowe et al., 1996). Two family types engage in maladaptive, dysfunctional interaction patterns (e.g., they have lower cohesiveness,
lower expression, and greater interpersonal conflict)—termed sullen and hostile—and have morbid psychosocial outcomes for many of their members. Hostile families are chaotic and help-rejecting, while sullen families carry the highest rates of depression, yet accept help (Kissane et al., 2003). The fifth family type, termed intermediate, shows moderately reduced cohesiveness (Kissane, Bloch, Dowe et al., 1996), and members are also at heightened risk of having poorer psychosocial outcomes (Kissane, Bloch, Onghena et al., 1996). An avoidant family type has also been posited, in which family members may hesitate to become involved in research (Kissane & Bloch, 1994).

Our prior empirical work found that some 50% of families in the palliative care setting resemble the two well-functioning types, while 15% carry features of the two dysfunctional types, with this rate increasing to 30% during early bereavement before returning to pre-death levels. Intermediate families comprise 30% in the palliative care setting (Kissane et al., 2003), often becoming more dysfunctional in early bereavement as the stress of loss reverberates among their members. The names and descriptors applied here assist understanding, but are never used as labels in the clinical setting. Rather, the typology permits screening with the FRI to identify those “at risk” of morbid outcomes, who can then be invited to meet together with a clinician.

Data for this study were collected from 701 relatives of terminally ill patients in six Australian community-based palliative care programs to screen for randomised clinical trial eligibility. The trial tested the efficacy of a prophylactic, family-focused psychosocial intervention to improve coping during palliative care and bereavement for families deemed “at risk” (i.e., sullen, hostile and intermediate types). To maximise sensitivity, families were classified based on the poorest perception of family functioning by any family member. Relationships between family type and psychiatric symptoms were examined.

Findings bolstered the conceptualisation of sullen, hostile and intermediate family types as being at “increased risk” for poorer psychosocial outcomes. Family members of “at-risk” families reported significantly higher levels of depressive symptoms and higher levels of global psychological morbidity including somatisation (i.e., experiencing psychological distress as physical symptoms), obsessive-compulsive behaviour, interpersonal sensitivity, depressive symptoms, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Members of these dysfunctional and intermediate families also reported poorer social adjustment across domains of housework, work, social and leisure activities, relationships with children and extended family, and overall social functioning—regardless of partnered/marital status.

Further, differences in psychosocial functioning occurred across the two dysfunctional family types and the intermediate type. Membership in hostile families predicted higher levels of depressive symptoms, anxiety, and obsessive-compulsive behaviour compared with intermediate families, while it also predicted higher levels of anger and interpersonal sensitivity than sullen families. In turn, membership in sullen families predicted higher levels of anger, interpersonal sensitivity, paranoid ideation and psychoticism than intermediate families (Kissane et al., 2003). Compared with intermediate families, the more dysfunctional types also carried poorer social functioning across domains of housework, social and leisure activities, and overall social functioning. Finally, members of these two more dysfunctional family types who reported elevated depressive symptoms also reported poorer relationships with their children (Kissane et al., 2003). These data illustrate the decline in psychosocial functioning from well-functioning, to intermediate, and finally to dysfunctional family types.

Moreover, as it is theorised that adaptive communication patterns and familial cohesion may assist families in coping with anticipatory grief (Lichtenthal et al., 2010), the two dysfunctional family types and the intermediate type, who exhibit poorer communication patterns and/or cohesion, may show a lowered ability to cope with anticipatory grief. If the
ability to cope with anticipatory grief is reduced, such individuals may be more likely to experience the increased psychosocial morbidity that has been observed in the context of intense anticipatory grief (Levy, 1991). Lastly, these characteristic behaviours may also put such individuals at elevated risk for complicated grief (Lichtenthal et al., 2010), which itself is related to poorer psychosocial (Prigerson et al., 2009), biological (O’Connor et al., 2012), and physical health (Prigerson et al., 1997) trajectories.

Brief, routine screening with the Family Relationships Index to identify “at-risk” families, followed by preventative and continued psychosocial care, is thus recommended for individuals identified as belonging to dysfunctional (i.e., sullen and hostile) and intermediate family types.

**Theoretical models that underpin family grief therapy**

Although our model of Family Focused Grief Therapy was developed empirically (Kissane & Bloch, 1994), there are theoretical models that have guided our thinking. Foremost models for forming therapy that focuses on relationships within the family as a group are attachment theory (Bowlby, 1969) and processes of group adaptation (Whitaker & Lieberman, 1964). In the setting of mourning loss, both pre-existing resilience (Bonanno, Wortman, & Nesse, 2004) and cognitive processing with meaning construction (Creamer, Burgess, & Pattison, 1992) make a contribution. Here, we elaborate on each of these.

**Attachment theory**

Families provide the most significant relationships, whether these be parent–child in the family of origin, or between spouses or siblings in nuclear families (Shaver & Tancredy, 2001). The deeper the bonds of attachment, generally the more heartfelt are the emotions of grief (Ainsworth & Eichberg, 1991). The process of sharing these emotions among family members initiates the potential for adaptive coping via mutual support. Family Focused Grief Therapy makes use of both components of the dual-process model (Stroebe & Schut, 2001), wherein oscillation occurs between expressing waves of grief and stepping back into the activities of family life. Optimising family functioning helps individuals to work towards the resolution of mourning through open communication, nurtured cooperation and active support. Variations of attachment style, whether secure, anxious, hostile, or avoidant and withdrawing, can be recognised in the patterns of relationship transmitted across generations and can be explored to consider their potential to either help or hinder adaptive mourning.

**Processes of group adaptation**

The family forms a group whose discussions move back and forth between liberating and constructive or protective and constraining solutions, as some relatives suggest generative ideas, while more fearful relatives urge caution (Whitaker & Lieberman, 1964). The family’s debate often searches for consensus, with adaptive outcomes resulting from constructive views. From time to time, a dominant individual may impose a restrictive viewpoint. Others may be indecisive but follow the views of the majority. Disagreements create conflict, dividing the family and handicapping desirable teamwork. The essence of a mature and well-functioning group is its cohesion, which in turn allows creativity, humour and joy to emerge (McKenzie, 1995). Similar goals exist for both group and family therapy.

**Pre-existing resilience**

When bereaved, adaptive families deal with their loss via their strengths and robustness (Bonanno et al., 2004; Boss, 2006; Shapiro, 2008), therapists wisely follow this lead by affirming evident strengths and avoiding undue criticism of the family (Zaider & Kissane, 2007). The natural support network of the family serves as a source of its inherent resiliency (Boss, 2006). We aim to harness these strengths to promote adaptation. Rather than being limited by kinship, the family comprises those persons who can be effectively rallied to be supportive and willing to help (Landau, 2007). Good friends, neighbours or relatives from the extended family may all bring compassion, thoughtful concern and generous care provision to the bereaved. One of our golden therapy rules is to have therapists search for identifiable strengths that can then be endorsed as an aspect of their resilience.

**Cognitive processing and meaning construction**

The achievement of an integrated understanding of the life event, illness or death results from successful cognitive processing (Janoff-Bulman, 1989), including making sense of what has happened in accordance with previously held belief systems and assumptions about the world and how it works (Parkes, 1998). This constitutes a schema of ideas, values, attitudes and beliefs that we use to organise
our understanding of the world, and cognitions that we adapt to accommodate any new traumas or events. Thus, illness and death lead to revisions of this schema. Within the family, disclosure of thoughts and feelings shapes their collective world views (Janoff-Bulman, 1989; Janoff-Bulman & Berg, 1998), leading to cognitive reappraisal as either confrontation or avoidance strategies unfold.

Patterns of communication and conflict resolution influence the level of understanding that is achieved. Negative views are often challenged by thoughtful family members, who then guide the appreciation of positive meaning (Folkman & Moskowitz, 2000). Culture and tradition influence the regulation of mourning, recognising when some avoidance is protective, but too much harmful. Cognitive reframing occurs iteratively, using the diverse views of family members to brainstorm options, search for solutions, and then help each other to find new meaning in what has occurred. The roles that members adopt also bring new sources of meaning (Neimeyer, 2011) as change is accepted and grief resolution begins.

Delivering family therapy in palliative care and bereavement

Palliative care services have increasingly accepted the wisdom of holding a routine family meeting at entry to their program in order to assess needs, educate about care-giving and plan for the events that lie ahead.

As the story of the cancer and its treatment unfolds, the clinician can readily intersperse questions about the "three Cs" of family relational life: communication, cohesion and conflict. Alternatively, assessment of the family’s level of adaptive functioning (e.g., through administration of the FRQ) can help identify those at greater risk of psychosocial morbidity.

Where a family acknowledges concerns about the quality of its communication, the nature of its teamwork and level of support, or its difficulty in resolving conflict and differences of opinion, then the clinician can invite the family to continue meeting to assist these identified domains. Thus, a plan for continued family work is established.

Techniques, strategies and challenges

Appreciation of the family’s history across three generations, through construction of a genogram (e.g., a pictorial representation of a family’s history and relationships), allows for recognition and naming of any patterns of compromised relationship behaviours that have been transmitted from generation to generation. Such family scripts free the family from blame, as they appreciate the manner in which behaviours have been modelled from one generation to the next (Byng-Hall, 1988). Attention to relational patterns and coping responses to loss events proves very informative. When families realise how readily a pattern has come down through the generations, they can be invited to commit to alternative approaches to relating.

The protective urge found in every family makes discussion of the severity of illness and risk of dying hard. Therapists must look for opportunities to encourage families to consider their future, with the chance to express preferences about instrumental care provision tasks, place of dying and even funeral consideration. A focus on the importance of quality of life helps sustain constructive hope in the face of any death talk. When the family accepts a conversation about death and dying with openness and courage, the opportunity to celebrate the accomplishments, meaning of life, value and dignity found in the sick person also presages the chance to say goodbye. If the illness is less advanced, or the family seems unready to enter such a conversation, the wise therapist patiently respects their need and awaits a later opportunity.

Maintenance of the safety of any family conversation is a fundamental responsibility of the therapist. Many families initially defer grappling with conflict until they gain a sense of the therapist’s ability to help. Others jump right into their battleground, whereupon the therapist must be deft at containment via exploratory questions about process rather than content—setting limits where needed, to model respectful processes through which opinions are shared. Escalation of conflict through the perception that the session is no longer supportive or safe will quickly lead a family to withdraw in its effort to prevent further harm.

The therapist should expect to be invited to take a side with one party or another in a dispute. This invitation is a trap for the unwary, highlighting the importance of therapist neutrality, while aiming to have the family explore solutions to its issues or concerns. Moreover, the circular questioning style of therapist activity is very different to the linear operations by an individual therapist. Thus, rather than routinely having the therapist express empathy to an individual when an empathic opportunity emerges, more benefit is achieved through fostering empathic exchanges between family members as they...
move to support somebody who is distressed. Circular questions invite one member to offer ideas about the feelings, experience and even suffering of another in the family circle, encouraging each to step into the shoes of the others, and thus facilitating a process of mutual understanding and, hopefully, support. Hence, therapists move between asking thoughtful questions and checking understanding via integrative summaries that help pace the therapy and keep the family's experience to the forefront.

As the therapist gets to know the family and understand its relational style of functioning, efforts are made to discover family strengths alongside vulnerabilities. Praise and affirmation of robustness is a key goal of this therapy, as this strategy becomes an important pathway for bolstering family wellbeing in the face of their adversity. Family customs and traditions, ethnic backgrounds, perhaps a motto, stories of accomplishment and legacy, spirituality or religious heritage, use of humour, educational successes, career paths, reproduction and parenting, pride in the next generation, even generosity as caregivers, are grist for the mill in discovering things to admire about the family and summarising its strengths in a list of praise. Care is always taken to re-label any easy criticisms that arise in many families. Appreciation for the motivations behind any behaviour, the diverse expectations that exist among family members, their different alliances, or a perspective that externalises an unwelcome behaviour can all help to avoid blame. As the therapist models curiosity and respect for all in the meeting, so that therapist hopes that the family will follow this lead in a constructive path of openness to new experience.

The process of therapy

After one or two meetings that follow closely one upon the other, and as an agenda is created to which the family agrees, the frequency of meetings can be tailored according to need, often settling into meetings every three or four weeks in support of the focused agenda. The health and wellbeing of the cancer patient are of primary relevance to this. Meetings in the home are normative in a palliative care phase, as the patient becomes too ill to travel, and the advantages of the transportability of the therapy are apparent. Meetings in the inpatient setting are also invaluable for capitalising on potential crises as opportunities for transition and potential motivation to change. Therapists wisely seize the chance to attend funerals to foster the therapeutic connection, while also signalling their deep regard for the bereaved.

Continuation of therapy post-death sustains the continuity of care and builds helpfully on the family’s relationship with direct knowledge of the deceased, whose comments, wishes and motives can empower the direction of subsequent sessions.

Active sharing of family grief is the norm during bereavement work. The construction of new meaning, fresh roles and varied relations is sought. As signs of resolution emerge, the length of time between sessions is gently increased to two-monthly and then three-monthly intervals, and termination is openly prepared for. This includes future relapse prevention strategies that acknowledge the likelihood of old habits returning and considering future approaches to sustain the current direction and momentum. Closure brings the offering of congratulations to the family in this strengths-based model.

The efficacy of family grief therapy

Evidence of the efficacy of Family Focused Grief Therapy was first demonstrated in a randomised controlled trial of 81 families (353 individuals) (Kissane et al., 2006). Families were randomly assigned in a 2:1 ratio to receive either the intervention \( n = 53 \) or standard palliative care with no prescribed family support \( n = 28 \); 40 (75%) of the families allocated to intervention completed the therapy. Delivery of the therapy was standardised with a manual, extensive training and supervisory support to ensure fidelity to the model (Chan, O’Neill, McKenzie, Love, & Kissane, 2004). The number of sessions provided was not predetermined in this study, and averaged close to four per family (range 0–13). Participating family members completed measures of distress and family functioning at enrolment (baseline assessment) and then subsequently at 6 months and 13 months post-loss. Although perceptions of family functioning remained unchanged, Family Focused Grief Therapy was associated with a
significant reduction in individual members’ distress after 13 months of bereavement. Significant reductions in both distress and depression were especially prominent for the 10% of family members most distressed at baseline, with a trend toward improved social functioning for this subgroup.

A second randomised controlled trial was mounted to determine what dosage of therapy is needed to optimise adaptation and prevent morbidity outcomes in bereavement. In this second trial, 170 families (620 individuals) were randomly assigned to receive 6 or 10 sessions of Family Focused Grief Therapy, or usual palliative care. As this trial is currently near completion, we present here preliminary data on key outcomes. Promising trends showing prevention of distress in bereavement emerged in preliminary analyses: greater reduction in scores on the Beck Depression Inventory-II (BDI; Beck, Steer, & Brown, 1996) was evident for individuals receiving therapy, compared with the families receiving standard palliative care.

For example, mean BDI score for families in the six-session arm was 14.6 (SD = 9.1) at baseline and 9.4 (SD = 7.6) at 6 months of bereavement, while mean BDI score for families in standard care was 13.5 (SD = 8.9) at baseline and 11.2 (SD = 10.2) at 6 months. Selecting the 15% of participants with the highest distress scores on the Brief Symptom Inventory-18 global scale (Derogatis, 2001), a linear mixed effects model (Raudenbush & Bryk, 2002) comparing the change scores across intervention conditions (adjusted for baseline) showed statistically significant reduction in depression scores.

The potential of this model of therapy to prevent complicated grief disorder (described previously) is also evident from this recent trial, in which the Complicated Grief Consensus Criteria (Prigerson et al., 2009) was used to compare the prevalence of CGD among family members who had reached bereavement. Examination of the first 174 participants at 6 months post-loss yielded CGD rates of 25% among those receiving standard care, compared to 16% among those receiving any Family Focused Grief Therapy.

Finally, in an effort to capture proximal changes across sessions of therapy, family members were asked to report on the degree of communication perceived in the family following each session. These data were collected for 58 families (196 individuals) across the first four sessions of therapy. Data were pooled across the six- and ten-session arms since the content of these sessions, as prescribed by the manual, is similar. Changes in communication across sessions were examined using linear mixed effects modelling to account for clustered data. Although variation could be found across individuals’ trajectories, results suggested that, on average, family members perceived a significant overall increase in communication across these sessions (β = 1.26, se = 0.18, t = 7.07, p < .001). These preliminary data provide support for a hypothesised change mechanism in this model, namely the opening up of communication and expression of concerns.

Challenges in dissemination

Family Focused Grief Therapy has demonstrated promise as an intervention that can be delivered across multiple settings and with sensitivity to families’ cultural needs. Because therapists become involved with families at the end of life, when caregiving burden increases and patients are less ambulatory, sustaining engagement in therapy can be challenging. Family Focused Grief Therapy has thus evolved into a model of support that can be delivered in the outpatient setting, at the hospital bedside, or in the home. Although therapists sometimes struggle to clarify and maintain the structure of therapy when it occurs outside of the consulting room (Del Gaudio, Zaidi, Brier, & Kissane, 2011), the flexibility and transportability of this model have become essential to its feasibility.

An additional dissemination challenge is ensuring that clinicians of various disciplines can be taught to apply Family Focused Grief Therapy effectively. Across the two randomised controlled trials, this model of therapy was taught to social workers, psychologists and psychiatrists, some of whom were trained in family therapy but had little direct experience with palliative care. Evidence of fidelity to the model of therapy across both trials (Chan et al., 2004; Del Gaudio et al., 2011) suggests that a diverse group of clinicians were able to work competently and faithfully deliver the therapy as prescribed. This could be achieved in part due to the availability of regular peer supervision, through which therapists could give and receive support, discuss clinical challenges and process personal grief reactions.

The adaptability of Family Focused Grief Therapy to families of differing ethnic backgrounds is made possible through the guided exploration of religious traditions, culturally based values and beliefs and use of ritual in families. In cultures where loyalty to family is highly valued, and family-centred traditions are strong (e.g., families of Asian and Mediterranean descent), this model has drawn particular interest, and therapists have been successfully able to attend to the
particular styles and coping responses arising from the family’s cultural background (Mondia, Hichenberg, Kerr, Eisenberg, & Kissane, 2011).

Conclusion

Family Focused Grief Therapy prioritises the family as the natural context in which individuals’ distress due to illness and loss is expressed and metabolised. Research on families in palliative care spanning the last two decades has provided a strong empirical basis for intervening early with the distressed family, and mobilising relational resources to ensure the long-term adaptation of its members. It is a relatively brief, manualised and transportable model of therapy that can be competently delivered by clinicians of various psychosocial disciplines. Across two randomised controlled trials, evidence of its efficacy has emerged, and the capacity for sessions to directly affect family communication has been demonstrated as well. Importantly, working with the family as a whole often enables recognition of individual members’ emotional needs, and therefore is an approach that easily complements other modalities of support. The continuity of care prior to and following the adverse life event—in this case, loss of a loved one from illness—is a unique aspect of this therapy, and presents an opportunity for families to change the course of their adaptation.

References


Working with the family as a whole often enables recognition of individual members’ emotional needs, and therefore is an approach that easily complements other modalities of support.


Dr Tammy Schuler and Dr Talia Zaider are at the Department of Psychiatry & Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, New York, USA. Dr David Kissane is Head, Discipline of Psychiatry, School of Psychology and Psychiatry, Monash University, and Adjunct Professor of Psychiatry, Weill Medical College of Cornell University, USA.