British Journal of Psychiatry (1994), **164**, 728–740

Review Article

Family Grief

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As grief is both an individual and shared experience, adopting a systemic perspective is most appropriate for health-care professionals seeking to assist the bereaved. Within this framework, the family virtually always constitutes the most significant social group in which grief is experienced. In this paper we review the literature on family grief, covering clinical case reports, the observations of family therapists, systematic family bereavement research and family intervention studies. An understanding of patterns of family grief and vulnerability factors for morbid grief is pivotal to both preventive intervention and treatment of an established disorder.

Over a quarter of a century ago, Paul & Grosser (1965, p. 339) lamented that:

> "Psychologists (and, indeed, other mental professionals) seem to have little to say if we must judge from the dearth of psychological literature on the phenomenon of shared grief and its resolution as experienced by a family when a loved one dies."

The observation continues to remain valid. The literature includes several reports of case studies but systematic research is relatively uncommon. Moreover, the literature on family grief in general remains limited in quantity and scope. In contrast, a substantial amount of conceptual and empirical research has been conducted on individual grief. It is not surprising that the study of family grief has remained underdeveloped and non-cumulative. Firstly, given the prevailing research paradigm associated with the natural sciences, the individual has long constituted the focus of the mental health professional and behavioural scientist. Secondly, methodological hurdles facing the researcher when the family is the target of investigation are considerable, indeed, intimidating (Middleton & Raphael, 1987).

Our purpose in this paper is to review the literature on family grief over the past 25 years. We do so using three headings: clinical case reports and observations, systematic research, and intervention studies. Although this is an arbitrary approach, it is clearer to present the findings in these reasonably distinct domains. We also extrapolate, where appropriate, from evidence derived from studies on individual and conjugal bereavement. Finally, we discuss potentially useful approaches for future research.

Loss, of course, can take many forms, ranging from divorce to loss of a limb (Parkes, 1972) or loss of health (Zarit & Zarit, 1984; Miller *et al*, 1990). While the reader may extrapolate the findings of this review to other types of loss, we focus directly on bereavement as our model.

We launch the review by considering clinical case reports and observations, in fact the largest of the three domains, reflecting the predominantly clinical interest in family grief.

Clinical case reports and observations

Case reports

Jensen & Wallace (1967) were among the first observers to emphasise the family dimension of grief when they reported on two families in which the involvement of parents with a remaining offspring, after the loss of one family member, became problematic. Avoidance of grief had led to family dysfunction, culminating in symptom formation.

Berkowitz (1977) also stressed the inhibition of emotional expression; he commented on the 'covertly collusive fashion' whereby the three families treated concealed their grief which therefore remained unresolved. Moreover, this avoidance of grief was associated with parental over-protectiveness and rigidity. Symptom formation ensued because of this dysfunctional family pattern.

Black (1981) reported on three families assisted by counsellors following the death of the mother. The counsellors used modelling to encourage the family to talk about its loss and share feelings; the husband was also helped to resume his parental role. Promotion of communication between family members was a pivotal aspect of the intervention.

Gelcer (1983) adopted a systemic perspective in treating two grief-stricken families. Both involved adolescents presenting with behavioural difficulties several years after the death of one parent at a vulnerable point in the family's life cycle. Various family subgroups were seen in the course of therapy,

including meetings with individual members. However, when individual therapy only was provided, this served to isolate the person from the family.

Gelcer reflected on a social trend for contemporary families not to be exposed to loss with anywhere near the frequency that ancestral social groups once were, and on the related tendency to abandon traditional customs and religious rites previously used to facilitate mourning (Imber-Black, 1989, 1991).

Bloch (1991) reported on the treatment of three families which had not dealt with their grief for several years after the loss. In each case, a member had presented as a long-standing 'symptom bearer', reflecting the inadequate adjustment made by the family. Two families illustrated a pattern whereby grieving parents were emotionally unavailable to their children who were then unable to express their grief. Such avoidance was evident in the family's poor communication and inhibited emotional expressiveness about the deceased.

Bloch highlighted the difficulty of engaging family members in treatment when a collusive, defensive pattern had become entrenched. As with Gelcer, therapy could only proceed by working with specific subsystems – individual, marital and other family subgroups – on issues that they could grapple with, before shifting to another relevant part of the system.

Comment

In all the above case reports, avoidance of grief was associated with family dysfunction, which in turn contributed to symptom formation. It remains unclear whether grief avoidance is causative of, or consequent upon, family dysfunction. However, until the family dimension was addressed systemically, the unresolved grief proved resistant to therapy, a matter vital for clinicians conducting grief therapy to appreciate.

Clinical observations

We now turn to clinical observations made by family therapists and other clinicians who have emphasised the relevance of a systemic approach to grief but who have stopped short of undertaking empirical research. Osterweiss and her colleagues (1984, 1987) highlight this approach in their useful reviews of research into the biopsychosocial aspects of bereavement.

Some interesting clinical contributions have emerged in terms of *patterns of family response* to the death of a member. Lily Pincus (1974) in her classic *Death and the Family* was among the first to draw attention to this aspect of grief, using a psychoanalytic perspective. For instance, she contrasted the potential regressive response of a bereaved spouse with the more likely growth-oriented outcome in adult children who had lost a parent. More recent notable contributions are those of Bowlby-West (1983), Lieberman & Black (1982) and Raphael (1984).

Bowlby-West has helpfully identified six maladaptive responses which the family may develop in order to achieve a new equilibrium. These are:

(a) Adoption of a common coping style, such as displacing blame, idealising the deceased or identifying with the deceased. A dominant member may lead the rest of the family to assume a particular stance which may prove adaptive for some but maladaptive for others.
(b) Sealing off family boundaries, thus producing greater enmeshment that protectively enables the family to deal with grief privately.
(c) Promotion of a family secret, which serves to uphold the family's pride at the expense of completing the work of mourning; this is especially likely to occur following suicide.
(d) Assumption of inappropriate roles, well exemplified by the parentification of a child following the death of a parent.
(e) Transgenerational rekindling of incomplete mourning of previous losses of members of the family of origin. This may serve to amplify the current grief within the family and thus induce dysfunction.
(f) Family dependence on religious rituals and cultural traditions may accentuate differences between members where varied views and practices already exist. A clash between the individual and his culture may occur, illustrated by religions that refuse a mourning ritual for a stillbirth.

Lieberman & Black (1982) have similarly emphasised the interplay between individual and family responses to loss. In a predominantly clinical paper, replete with a wide range of interesting case histories, tentative categories of pathological family grieving are identified including avoidance, idealisation and prolongation. Lieberman & Black suggest that these patterns of response parallel, and indeed amplify, those encountered in individual grief. Family disintegration such as divorce or separation are understandable developments resulting from this magnificatory process.

Raphael (1984) described seven family response patterns in which a particular style, based on 'myths' or tradition, influences the outcome of grief:

(a) The family in which death is taboo; silence is the *modus operandi*. This style stems from the

https://doi.org/10.1192/bjp.164.6.728 Published online by Cambridge University Press

family of origin, where there is commonly unresolved grief over the loss of the parents' parents.

(b) The family in which someone must be to blame; again this style is transmitted through the parents, their rigid control leading the family to generate guilt and to seek out one or more persons on whom to project blame.

(c) The family in which intimate relationships are avoided; the family shuns intimacy and conceals distress in the erroneous belief that it is too risky to permit closeness.

(d) The family whose members insist that life must continue as previously; since there is little flexibility of roles, the deceased's role must be filled promptly for the maintenance of the system. Grief is avoided for fear that it would undermine the system.

(e) The family for whom loss means chaos and a risk of family disintegration; such a family has limited resources, their networks of support sharing their deprivation. They have often experienced separation, divorce and mental illness.

(f) The family that must do the right thing; while this may be reasonably adaptive, the family battles against primitive feelings, often intellectualises and fears that disaster is imminent.

(g) The family that functions with openness and honest sharing of feelings. The family is adaptive in tolerating positive and negative feelings; members are intimate with one another and share their distress. Mourning progresses through mutual care and consolation.

These three attempts to delineate family grief patterns have identified several features – some adaptive, but mostly maladaptive such as avoidance, distortion, inflexibility and loss of cohesiveness. They point particularly to transgenerational influences and the persistence of a family style (Paul & Grosser, 1964; Welldon, 1971). One paradigm for understanding this cross-generational influence is presented in the work of Ainsworth & Eichberg (1991), who found a significant correlation between the parental pattern of attachment behaviour (e.g. secure–autonomous, insecure–anxious and insecure–avoidant) and the quality of attachment found in children. Furthermore, mothers with unresolved mourning for the loss of an early attachment figure were found to have an increased likelihood of rearing infants with an insecure–disorganised attachment to them. This pattern of transmitting insecure attachments across the generations maintains a family style which may well have adverse effects on the subsequent mental health of family members.

Byng-Hall (1988, 1991) has ingeniously approached the issue of family style through his concept of the 'family script'. The script encodes the family's behaviour for future situations. Thus, mechanisms such as denial of death and identification with and replacement of a family member provide a means to replicate scripts, which then tend to generate problems for subsequent generations. 'Corrective' scripts prescribing behaviour to avoid previous painful experience may also be maladaptive, inhibiting an effective family grieving process. Byng-Hall's notions are particularly helpful in determining family factors influencing the current response to loss.

The concept of *family structure* has also been applied to the family experiencing grief with Minuchin & Minuchin (1987) to the fore. Munson's (1978) contribution, describing the family's grief upon the loss of a child after a terminal illness, utilised Minuchin's structural model. He highlighted the fundamental features of the family group, namely its division into various subgroups, each with its own tasks and responsibilities, e.g. marital, parental and sibling, and the degree of permeability between these subgroups; he also focused on the level of flexibility of family functioning. Family dysfunction occurred with extremes of flexibility, either too rigid or chaotic, or when the family, in terms of its boundaries, was either enmeshed or disengaged. Thus, for instance, parents could become absorbed by their grief, overlook their tasks and responsibilities, and fail to help their children to deal with their grief.

Munson also drew on the Minuchin approach to conflict resolution within the family. When conflict in the context of grief was not resolved, the two likely sequelae were either an agreement to disagree or denial of disagreement. In the former, coalitions developed; family dysfunction and symptom formation were probable when these coalitions involved members from different subsystems. In the latter, denial of conflict was usually achieved through displacement of affect, with hostility openly directed towards a scapegoat, often a child.

Inherent within the family structure are the *roles* filled by individual members. Death of a family member calls for reorganisation in this regard. Vollman *et al* (1971) were among the first to observe how significant the role formerly occupied by the deceased was in this reorganisation. This role was divisible into instrumental, referring to task-oriented functions such as being the breadwinner; or expressive, covering emotional functions like serving as the family's emotional 'barometer'. While the

instrumental role might be difficult to fill, the expressive role was more vital for family equilibrium, its loss leading to disorganisation and maladaptive behaviour. This role was also occasionally used to camouflage or resolve a conflict; in these circumstances its presence was crucial for the maintenance of family homeostasis.

Similarly, Bowen (1976) suggested that loss of a member whose role was 'emotionally' or 'materialistically' crucial would be followed by greater family disruption than the loss of a comparatively neutral member. Significant roles, for example, were a parent of a young family, a 'special' child or 'the head of a clan' (i.e. the family patriarch).

In addition to the role of the deceased, Bowen (1976) also emphasised the relevance of *family communication* as a determinant of the pattern of grief. Communication in his clinical experience was either closed or open. If closed because of the patient's withdrawal into himself, the family's avoidance or the physician's jargon, adverse effects upon family grief ensued. Bowen strongly recommended that clinicians working with the terminally ill and the bereaved should be direct and explicit in their use of language. Although this recommendation has been repeatedly made by other workers in the field, the general topic of communication patterns in the grieving family has not been carefully researched.

Family support

Closely linked with open channels of communication is the experience of *support* derived from both within the family and beyond. Vollman (Vollman *et al*, 1971) drew on her experience of working with families following a sudden, unexpected death. Cohesive families with an intact supportive social network adapted successfully whereas 'closed' families, often to the point of being socially isolated, were at risk of poor outcome, and also resistant to therapeutic intervention.

Maddison & Raphael (1975) were also pioneers in concentrating on the relevance of support in terms of the bereaved person's perception of the degree of helpfulness of her social environment. When family support was perceived as unhelpful and feelings were not expressed, there was a greater likelihood of morbid grief. Working with widows, it was noted that siblings and children generated more helpful exchanges than in-laws or mothers, with female-linked networks especially important. Sisters and their daughters provided considerable support but a widow turning to her own adult or adolescent daughter tended to derive most benefit.

Parkes & Weiss (1983) also commented on the family system as a source of support to its members. In their 'bereavement risk' index, developed as a research instrument, one segment deals with the degree of intra-family support.

A lack of support, either objective or perceived, brings us conveniently to the theme of *loneliness*. Several clinical observers (Maddison & Walker, 1967; Parkes & Brown, 1972; Clayton, 1975; Raphael, 1984) have tackled loneliness as a salient aspect of bereavement. Glick and colleagues (1974) reported that 60% of widows felt lonely at 12 months, while Lopata (1979) found that half the widows in his study described loneliness as their cardinal problem. Weiss (1974) proposed a specific understanding of this experience as consequent upon loss of an adult attachment so that the family struggled to overcome it until a new attachment through re-marriage permitted ultimate recovery from loneliness.

Large (1989) has contributed innovatively to this theme in pointing out that families may accentuate the loneliness of one of their members, particularly in a setting of unresolved grief. He noted that the process whereby some families moved from a grieving state following an untimely death to chronic loneliness in one particular person was not well studied. One person might bear the extra sense of emptiness whereas other family members were spared, and thus able to function.

The loss of a child through death obviously has profound effects on both the parents and the siblings. The grieving process of the surviving children has been relatively understudied compared with that of their parents. George Pollock (1989) stands out as particularly observant of *the sibling experience*. He portrays sibling loss in childhood as a family tragedy but asserts that the loss assumes a different meaning for each family member; sibling loss, for instance, is more pathogenic for younger persons than for adults. Strained family relationships are reflected, *inter alia*, in parental overprotectiveness, formation of coalitions, parentification of children, blaming, competitiveness for attention, social isolation or parental inability to support and emotionally care for their surviving children. Sibling rivalry is linked to guilt, anger, envy, shame, responsibility for or identification with the deceased, all of which may distort the mourning process.

Haig (1990) also approached this problem but from a somewhat different point of view. Following the loss of a baby, a fundamental change in parents' belief about the future security of their family occurs. The parents may remain anxious and persistently fear for the safety of their surviving children, such that a subtle but adverse developmental effect is transmitted to them.

Worden (1991) addresses siblings' experience of loss but concentrates on intervention. Thus, careful

attention needs to be paid to siblings in order to dispel erroneous and magical thinking about the death (see also Horowitz *et al* (1984*a*,*b*) and Krupnick & Horowitz (1985) for their recommendation of an 'educational' model to prepare children for, or to inform them of, a family member's death). Families also need to take care that surviving or replacement children are not 'exploited' to fill the empty space. When teenage children are bereaved, Worden urges the therapist to ascertain the new roles they may come to occupy, as these can be subtlely and inappropriately reassigned in the context of formation of major new alliances.

Worden also usefully highlights the experience of *the elderly bereaved* for the family system. The elderly develop deep attachments through marital interdependence, entrenchment in family roles, experience of multiple loss, personal awareness of death and profound loneliness. The family as a group may need to assist the elderly bereaved in adjusting to new roles and possible relocation, as well as provide support and promote a variety of skills rather than allowing undue dependence on adult children. As bereavement in the elderly may not have an endpoint, the family needs to be particularly respectful of the differential rate of grief among its members (Bowlby-West, 1983; Fulton & Gottesman, 1980).

Reference to death of a family member at the extremes of life reminds us of major events occurring as part of the *family life cycle*. Walsh & McGoldrick (1991) emphasise the salience of the cycle in the wake of any loss through death. The timing of a loss at different stages of the family life cycle generates different sets of circumstances that are in turn associated with the family's management of grief and its potential complications. Walsh & McGoldrick consider the particular experiences of loss in terms of a well thought-out schema of the family life cycle, devised originally by the latter (Carter & McGoldrick, 1980) as a framework for family therapy. Thus, they discuss loss experienced by unattached adults, the newly-married couple, the family with young children, the family with adolescents, the family with adult-aged children and the family in later life.

Walsh & McGoldrick (1991) also deal with untimely losses. These not surprisingly are more demanding for the family to come to terms with and tend to be associated with prolonged mourning. Shanfield *et al* (1984) similarly differentiate between predictable and untimely loss, placing considerable emphasis on the stage of the family life cycle.

Before concluding this section, we must remind ourselves of the relevance of cultural factors in influencing family grief responses. Eisenbruch's (1984*a*,*b*) masterful account of this dimension, including a vivid portrayal of grief patterns in a variety of cultures, emphasises that the response to loss is invariably culture-bound. Moreover, the pattern of mourning of an ethnic group provides an insight into the norms and customs of that group as its rituals seek to re-establish its social order. Rates of mourning, for example, vary widely across different cultures. In the face of cultural change, such as when families migrate to a country with an alien culture, there is a risk that their familiar bereavement practices will be shaped by the host culture, with this potentially hindering adaptive grieving.

Comment

Although the above observations have not been based on systematic empirical research, they comprise an interesting and intuitively important body of knowledge. The work on patterns of family response to loss is particularly noteworthy, serving to identify relevant questions that could in turn be converted into testable hypotheses. The implications for treatment and prevention of maladaptive grief are clarified to an important extent.

The observations on specific aspects of family structure and functioning as they relate to grief are also potentially useful as pointers to more systematic research. For example, the ideas on support and communication seem most apt, and warrant further attention, as does the role of the family life cycle.

Systematic research on family grief (excluding intervention studies)

Studies systematically examining family grief have been relatively few compared with clinical observations. The work can be conveniently divided into families experiencing the loss of an infant, a child and an adult. (The special circumstances of orphanhood have generated a considerable literature but one which is beyond our present remit; the interested reader is referred to Rutter, 1989; Tizard, 1977; Bohman & Sigvardsson, 1978.)

Grief and infant loss

Although the literature on perinatal and sudden infant death and the family has tended to focus on the therapeutic dimension (e.g. Bluglass, 1980; Woodward *et al*, 1985), including the role of family counselling (understandable given the tragedy of such an event and the clinician's inclination to intervene actively), the systematic study of family functioning and its relationship to the grief process has been well tackled by a small group of investigators. Their interest has, not surprisingly, revolved mainly around identification of at-risk factors and outcome effects

of the loss. Important themes are the differences between grieving mothers and fathers, the effect of the death on the marriage, the value of support to the family, the impact of both the suddenness of death and the length of relationship with the infant upon grief, the parental relationship with surviving children and the role of a replacement child. We now discuss each of these topics in turn.

Clear *differences in parental grief* have been found in several studies, mothers generally experiencing more intense and longer grief reactions than fathers (Benfield *et al*, 1978). Studying the response of 19 families to sudden infant death syndrome (SIDS), Cornwell *et al* (1977) reported that fathers experienced grief less deeply than mothers, and it resolved sooner. Similar findings emerged in the study of the experience of death from SIDS by Nicholas & Lewin (1986). Tudehope *et al* (1986) studied 67 families eight weeks after a neonatal death and noted that fathers were less willing to talk about their dead baby, maternal grief again appearing more severe. In a series of papers, Dyregrov & Matthiesen (1987*a*,*b*,*c*) retrospectively surveyed 117 parents 1–4 years following an infant death. Although in several couples fathers reported more intense grief than their partners, the mothers were generally more affected by the loss. Dyregrov & Matthiesen (1991) confirmed this pattern in a subsequent prospective study. They suggested that the difference in length and intensity between the grief of mothers and fathers could lead to misunderstanding and marital disharmony.

Few *marital relationships* appear unaffected by loss of an infant but as studies have not frequently been controlled or involved adequate sample size, it is not possible to conclude how frequently *divorce* ensues. Cornwell *et al* (1977) and Forrest (1983) reported that one-third of marital pairs encountered serious difficulty. A parent felt blamed for the child's death in some cases; in others fathers accused their spouses of extending family mourning unduly. Dyregrov & Matthiesen (1987) recognised that increased marital closeness for some and increased distance for others were possible outcomes.

Support of those in grief, actual or perceived, was examined as a factor influencing outcome by Forrest *et al* (1982), Tudehope *et al* (1986), Murray & Callan (1988) and Cordell & Thomas (1990). In investigating the impact of perinatal death on families, Forrest *et al* found that socially isolated women and those whose marriages lacked intimacy had a higher prevalence of psychiatric symptoms. Tudehope's group found that support for bereaved parents with perinatal loss was provided predominantly by each other (63%) and by their parents (33%). Pathological grief was found in a third of these families, especially where intra- or extended family support was perceived to be lacking.

Similarly, Murray & Callan (1988) studied support as experienced by parents suffering a perinatal loss two years earlier. The cohort was ostensibly a motivated one as it was recruited from perinatal death support groups. Hence, the finding that partner support was unrelated to grief outcome may have been influenced by the biased sample. However, their perception of a good level of support from doctors and nurses after the loss predicted better adjustment.

Because of the propensity for researchers to concentrate on mothers, Cordell & Thomas (1990) elected to assess the adjustment of fathers after an infant death. A supportive network again clearly enhanced adjustment; the support was derived from family and friends, attending a parents' support group or receiving help from a therapist. Cordell & Thomas viewed participation in a support group as a significant means of facilitating emotional expression, generating good communication between partners, and thus promoting mutual support within the relationship. All four studies reviewed thus identified support as a key determinant of outcome.

Other key determinants of outcome of grief in infant loss are the *suddenness* of the death and the *duration of the relationship* with the lost family member. Studies have compared death from SIDS with perinatal death. While Peppers & Knapp (1980) and Laurell-Borulf (1982) found no differences between grief intensity and length of relationship, their retrospective data collection occurred several years after the loss. Although also retrospective, Dyregrov & Matthiesen (1987) examined their cohort within four years of the loss (mean 27 months) and found that a SIDS death resulted in more intense grief than when death was perinatal. Theut *et al* (1990) contrasted miscarriage with perinatal loss (stillbirth or neonatal death) and found more intense grief in the latter group. Dyregrov (1990) has indicated that prospective and methodologically sound investigations are needed to shed light on this confused picture of the effects of the duration of the relationship.

The *relationship of parents to surviving children* is another key factor following an infant death. Cornwell *et al* (1977) identified increased protectiveness of the remaining child(ren) as the most common response but also noted that half the parents felt they had improved in that role in the year following the loss. By contrast, Bluglass (1980) described parents becoming overwhelmed by their grief and, hence, less available to support their other children.

The question of the advisability of *having a new child* soon after an infant loss was influenced by Cain

& Cain (1964) three decades ago in a key article in which they cautioned against a 'replacement child'. However, empirical research does not support this view (Peppers & Knapp, 1980; Videka-Sherman, 1982; Murray & Callan, 1988; Theut *et al*, 1990).

Peppers & Knapp (1980) found less intense grief among women who had given birth to a subsequent child. Similarly, Videka-Sherman (1982) observed that replacement with another child was associated with less depression. Murray & Callan (1988) found a significant association between reduced depression and a successful pregnancy following the loss. Theut's (1989, 1990) group noted that mothers wished to become pregnant again following an infant loss and hypothesised that this would facilitate grief resolution. They followed 25 families which had experienced perinatal loss in the previous two years and then subsequently gave birth to a healthy child. They demonstrated a reduction in grief intensity in both parents over the first 6 months of the new child's life. Although such parents were anxious about the viability of their new infant, the actual experience of the relationship, the authors postulated, enabled grief resolution of their prior loss to occur.

Arising from these studies on infant loss, maternal grief is clearly generally more intense and prolonged than that of fathers. Grief is modified by a supportive family environment and may ultimately be resolved only after the birth of a subsequent baby. Methodological problems pervade research in this area (e.g. retrospective and small samples, non-validated instruments), such that future studies are needed to clarify the impact of infant loss on marriage and on the relationship between parents and surviving and new children (Dyregrov, 1990). These methodological issues recur in subsequent sections on loss of the older child and the adult.

Grief and loss of a child

Systematic studies on the impact of the loss of an older child upon the family are sparse. The thrust of this research is about coping and the effect of the loss upon the functioning or survival of the family.

The study by Videka-Sherman (1982) examined *coping* strategies of 194 parents within 18 months of the death of a child, and again a year later. The cause of death was mixed, 57% sudden, 39% expected and some violent. A 'coping measure' was administered that explored the following strategies: escape (a form of avoidance), altruism (associated closely with participation in a self-help group), pre-occupation with the deceased, turning to religion or replacement of the child by a new role (e.g. new job) or another child (e.g. pregnancy, adoption). Positive outcome (a reduction in depression score) was associated with altruistic behaviour or reinvestment in another child or in meaningful activity. Poor outcome correlated with escape or considerable preoccupation with the dead child. As with infant loss, Videka-Sherman postulated that replacement of the child was adaptive in resolving grief by actively reinvesting love and energy in another person.

Coping was also a major theme explored by Davies *et al* (1986) in their study of grieving families who had lost a child. Several elements contrasting functional and dysfunctional families (as described by Crosby & Jose (1983)) were applied. Functional coping was characterised by open discussion, mutual empathy and respect between family members. Roles were flexibly approached, with the family able to re-organise itself to tackle tasks effectively. Functionally coping families readily utilised the resources of community agencies. Acknowledging the reality of their loss, they tolerated sadness alongside happy times, but gradually changed the perception of life to a more quality-based and hopeful focus.

In contrast, Davies *et al* recognised dysfunctional coping (prevalent in about a third of the families) when families blocked discussion, suppressed feelings of grief and concentrated on concrete events such as the funeral arrangements. They were unable to consider one another's needs, preoccupied as they were with their own individual feelings. Roles were rigidly maintained, change avoided, support rejected and religious beliefs unquestioningly adhered to. They expressed guilt about feeling 'good'.

Breakdown of the family as an outcome of dysfunctional coping was recognised by Nixon & Pearn (1977) in their study of families experiencing childhood drowning, matched against families where a near-fatal water immersion had occurred but the child was revived. The grieving families fared worse on a variety of indices, including a 24% parental separation rate over the first five years, compared with none in the control group. The siblings of one-third of the fatal cases developed emotional and behavioural problems. The retrospective nature of the study precluded accurate assessment of pre-accident family morbidity, but poor family cohesion and marital conflict were reported to be common.

While small in number, these studies by Videka-Sherman (1982), Davies *et al* (1986) and Nixon & Pearn (1977) cogently exemplify the stress that childhood loss imposes on the family. The risk of dysfunctional coping and family breakdown is high, especially when families fail to acknowledge and share their grief. Since the death of a child is untimely, often sudden and experienced as tragic, preventive intervention to reduce morbidity is warranted and needs future study.

The pattern of response to a child's death in the extended family is rarely examined. Grandparents obviously may play a special role *vis-à-vis* their grandchildren. Ponzetti (1992) has explored this aspect in a study by comparing the grief reactions of parents and grandparents within the same family. Affective changes were similar, but parents' reactions centred on the dead child whereas grandparents' concerns focused on their own children, i.e. the parents of the deceased child, suggesting that their own parental role was more significant to them.

Grief and adult loss

Systematic research into adult death needs to take the family life cycle into account, with untimely death in the literature represented by that of the younger adult from cancer (Shanfield *et al*, 1984) in contrast with the expected death of the elderly (Malinak *et al*, 1979; Norris & Murrell, 1987; Bass *et al*, 1991). Sudden death may not only be untimely but also unexpected and therefore carries an added risk (Shanfield & Swain, 1984; Parrish *et al*, 1987; Walters & Tupin, 1991). The experience of anticipatory grief (Rolland, 1990, 1991) also influences the process of mourning and is well exemplified by the work of Reiss (1990).

Shanfield *et al* (1984) studied the reactions of 24 parents to the death of an adult-child from cancer; 70% of the sample reported continuing grief two years following the death. It appeared as if grief could be reasonably prolonged when it was experienced as untimely in the context of the family life cycle. Shanfield *et al* found greater family intimacy in a substantial proportion, suggesting that a positive outcome might still occur despite the tragedy of the loss.

Another study undertaken by Shanfield & Swain (1984) focused on the effect on families of the *suddenness of loss* of an adult-child as a result of a motor car accident. Although 90% of parents were still grieving intensely two years later, with high levels of symptomatology (e.g. a third reported marked depression), a substantial proportion indicated that the quality of family life had improved.

Parrish *et al* (1987) further expanded our understanding of problems associated with sudden adult death in their investigation of care delivered to relatives by the staff of accident and emergency departments. A third of the 66 survivors interviewed indicated that they had received average or worse than average care. The need for explicit information about events was rated as an important means to achieve an understanding of what had happened.

Recognising that the sudden, unexpected and traumatic nature of deaths seen in casualty departments might predispose family survivors to morbid grief, Walters & Tupin (1991) have developed helpful clinical management guidelines. Staff need to become adept in updating relatives regularly about the condition of a critically ill family member and in supporting them during the process of notification of the death. They should also facilitate emotional expression by the family and offer support while they view the body. Moreover, the family requires guidance about autopsy, contacting funeral directors, notifying relatives, and the 'separation' process that helps them to know when it is appropriate to leave. Finally, provision of a means of follow-up is vital.

In contrast to such sudden and untimely deaths, adult loss is commonly expected and synchronous with the family life cycle. *Personal growth* may result from such loss. Thus, in a descriptive study, Malinak *et al* (1979) sought to identify adult reactions to the death of a parent and stressed the importance of the final farewell; they also found that many of the bereaved experienced personal growth in the aftermath of the death.

Bass *et al* (1991) followed 73 care givers through the illness and death of an elderly relative. Perception of *support* during this phase of care-giving was more predictive of the pattern of family bereavement than support post-death. Thus when *family tension* was evident during the care-giving period, complicated bereavement was significantly predicted. When important helpers to the care giver were only immediate kin, the survivors later perceived greater difficulties in grieving. Significantly, a professional as a member of the helping group protected against complicated bereavement. Bass and his colleagues suggested that the professional contribution might have benefited families by providing instrumental assistance and education, and promoting communication among family members.

Further investigation of *family stress* and adaptation before and after death, controlled against a non-bereaved cohort, was undertaken by Norris & Murrell (1987). Family stress was a weighted sum of scores on eight variables including ill health, hospitalisation, change of residence, family and marital conflict and change in family roles. Family stress mounted as death approached and diminished thereafter but individual distress as measured on a depression scale increased following the loss.

Anticipating loss

Families may experience *anticipatory grief* as they observe their relative entering a terminal phase of illness. In evaluating the family's adaptation to this transition, Reiss (1990) undertook an important and methodologically sophisticated project involving the prospective study of patients with end-stage renal disease, their families and medical staff.

As the illness deteriorated and entered a terminal phase, Reiss observed the family's realignment, designed to reduce stress, and reinforcement of the patient–staff relationship ties. One dimension of the latter was the staff's more authoritative role in offering support to family and patient. When a family did not establish this 'composure' in the terminal phase, bereavement became complicated. Acceptance of death played a critical role in re-establishing an equilibrium among the surviving family members. Furthermore, Reiss observed that family overinvolvement during the chronic phase of illness, together with a rigid rather than 'sensible' attitude to compliance with treatment, was associated with family 'burnout', culminating in the patient's earlier death and the family's vulnerability to complicated bereavement.

These studies of adult loss highlight the difficulties generated for families by untimely or sudden loss in contrast to the adjustment that can be achieved during the phase of anticipating death, i.e. when it is expected and timely. Support is a pivotal dimension in facilitating adaptive grieving; professionals have a major role in this regard in both expected and unexpected loss. Patterns of family functioning during a terminal illness and following a loss are highly relevant in determining the nature of grief outcome, yet methodologically sound prospective studies of this subject are uncommon.

Studies of family intervention

In their pioneering study on 'operational mourning', Paul & Grosser (1965) described a therapeutic approach in which families were encouraged to reflect on their loss, share associated feelings and attempt to understand the impact of the death on themselves.

Since the work of Paul & Grosser, only four studies have been done on the application of family therapy to grief. The findings are strikingly inconsistent, especially if we compare the work of Lieberman (1978) and Rosenthal (1980) on the one hand with that of Williams & Polak (1979), and Black & Urbanowicz (1987) on the other.

Lieberman (1978) reported on the treatment, using Paul & Grosser's approach, of 19 patients with morbid grief. Family participation facilitated the identified patients' acceptance of their loss. Twelve of the 13 patients in which the family was involved benefited compared with three of the six who received individual therapy, a statistically significant difference.

Rosenthal (1980) examined the effectiveness of family therapy for morbid grief following the death of a child or adolescent in a sample of 15 families. Regression was a pathological feature found in a number of parents whereby they sought to have their dependency needs met by their children. Although the study was uncontrolled, positive results were obtained from ten sessions of family involvement. Facilitating parents' greater tolerance of their own grief led to positive change for the whole family.

In contrast to this pair of investigations, two other studies on family intervention failed to show change. Williams & Polak (1979) applied a crisis intervention model to families who had lost a relative in a motor car accident. A therapist accompanied the coroner's staff to meet the families within hours of the death and subsequently provided an average of five counselling sessions. The treated group was matched with two control groups, one bereaved and one non-bereaved. Apart from 'suddenness' of death, no assessment of risk factors for pathological grief was carried out. Rather than preventing morbidity, the investigators candidly conceded that they might have disrupted 'natural' mourning through their unduly early intervention. In fact, the contribution was perceived as intrusive by the families and this may have reduced their inherent potential to grieve effectively.

The second study, by Black & Urbanowicz (1985, 1987), involved 100 families. Six sessions were convened with the goal of promoting mourning for a parent who had died. No selection was made of at-risk families. The attrition rate was high, with only 46% of therapy families and 53% of control families available for study at the end of two years. Outcome at a one-year follow-up showed superior health and behaviour in children and less depression in surviving parents of the treated group. But these differences waned at a two-year follow-up. However, more drop-outs had behavioural problems after one year and these were assumed to have persisted. Hence, difficulties in engagement and compliance may have disorted the results. Other factors possibly reducing inter-group differences included the acquisition of a substitute parent through remarriage in some families, and the 'therapeutic' influence of research interviews on the control group.

The impact of the loss on the child was substantially affected by parental well-being and the capacity to support the child when he cried or talked about the dead parent. Reconstitution of the family through a second marriage may have hampered the child's emotional adjustment through avoidance of talking about the dead parent in the presence of the substitute parent.

Apart from the intrusiveness of premature intervention as suggested by Williams & Polak (1979), studies have not reported deterioration resulting

from family intervention. Gurman & Kniskern (1978) reported a 5–10% deterioration rate for marital and family therapy generally but noted that such results were not likely to be published; this may be the case with the family therapy of grief. We are left, therefore, with inconsistent results from the family intervention work and corresponding uncertainty about which grieving families require professional help, and moreover, the optimal type of treatment.

Discussion

Coming to terms with the loss of a family member is obviously a personal matter in which the bereaved undergoes a highly individualised experience (Raphael, 1984). At the same time, however, it is clear that in the context of a family's loss of one of its members – be it nuclear, family of origin or extended family – all the bereaved continue to relate to one another, and, in so doing, their individual experiences of grief inevitably are influenced by and, in turn, influence the experiences of their relatives (Vollman *et al*, 1971).

This interactional pattern is likely to be even more pronounced in the case of a loss which occurs through a serious and often distressing illness such as cancer or after a traumatic loss like suicide. The family mourners in these circumstances are involved in a web of shared experience whatever their previous form of relating to one another.

Hitherto, valuable research has been done on grief as experienced by the individual. Useful knowledge has accumulated about patterns of grieving, complications, and risk factors that should alert one to the need for early therapeutic intervention (Raphael, 1984; Parkes, 1980). Thus in the case of pathological grief in the individual, various forms have been observed including: (a) avoidance, covering absence, inhibition or delay; (b) distortion, in which there may be idealisation of the deceased or intense anger; or (c) prolongation, in which grief may become enduring.

While research on pathological grief and associated risk factors has proved invaluable in providing an understanding of the process, the focus has been primarily on the individual, and crucial family aspects have not received appropriate recognition or systematic study. Only tentative steps have been taken to integrate systematically the study of family functioning as it relates to grief. Given that loss occurs invariably in a social context, especially the family, we need to direct attention to the question of how grief occurs in this broader setting and to identify how specific family factors may promote optimal grieving or, conversely, contribute to maladaptive grieving. The issues are taxing in that knowledge of this aspect of grief is rudimentary. We have comparatively little data about family grieving patterns, whether adaptive or maladaptive. We also have only scanty knowledge about which families are at risk for maladaptive grief. Furthermore, we are not well equipped to judge when and how to intervene, be it preventatively, or therapeutically after complications suggestive of morbid grief have ensued.

The gaps in knowledge cited here can be addressed because we have fortunately seen a substantial growth in the understanding of family functioning in the past two decades, through the widespread application of family therapy coupled with an increased scientific focus on family psychological process. This has been accompanied by the development of theoretical models of the family (see Gurman & Kniskern, 1991) as well as of multiple assessment instruments (Grotevant & Carlson, 1989). Major dimensions of family functioning, including cohesion, adaptability, patterns of communication, roles in the family, emotional expressiveness and the management of conflict have all been diligently studied (e.g. Satir, 1967; Minuchin, 1974; Reiss, 1981; Epstein *et al*, 1983; Olson *et al*, 1983). Longitudinal aspects of the family have also been tackled, with emphasis on the family life cycle (Carter & McGoldrick, 1980; McGoldrick & Walsh, 1991) in which predictable developmental tasks as well as accidental challenges have to be dealt with.

An understanding of family patterns of grief and a knowledge of at-risk families have important implications for health and morbidity in the general population. We would be better able to identify families vulnerable to maladaptive grief soon after the loss (or indeed in some cases even prior to death where a seriously ill member engenders particular patterns of anticipatory grief). This is obviously salient in terms of prevention since identification of at-risk families at an early stage may well prevent psychological and social complications from becoming established and, worse, entrenched (Bloch, 1991). Thus we are looking to a more preventive stance in obviating or minimising morbidity in the grieving family.

Such preventive intervention, through grief therapy in the main, is desirable but clearly only necessary for families at risk. Individual therapy (Melges & DeMaso, 1980; Mawson *et al*, 1981; Horowitz *et al*, 1984) is labour intensive when compared with a group approach such as with the family. Moreover, attention to the family system would be more apt, conceptually and clinically (McGoldrick, 1991). Indeed, it is conceivable that work with an individual may fail to accomplish its desired ends because of subsequent detrimental interaction within the family

system (Lieberman, 1978). A considerable advantage of intervention directed at the family is that it takes into account the specific needs of all its members. Obviously, some patients require parallel therapy (e.g. medication for depression) but this does not negate a systemic approach.

Through what mechanisms is the family able to influence grief outcome? The literature does not provide a clear answer. The coping style of an individual plays a pivotal role in working through the necessary tasks of the mourning process. But is there a correlation between such mechanisms and the coping style of the family?

In considering adaptive mechanisms, we are guided by the literature which suggests that effective resolution of grief is likely when a family shows the following features: cohesiveness (but without enmeshment), mutual support, clear communication, emotional expressiveness, ability to grapple with conflict, and adaptability.

Conversely, maladaptive grief seems to assume the following forms:

(a) *avoidance* of grief in families with poor communication, disengagement and stifling of emotional expression
(b) *distortion* of grief such as excessive guilt or anger when family members are enmeshed, blame or fight one another and cannot themselves resolve unavoidable conflict that typifies family life
(c) *prolongation* of grief when rates of grieving differ among family members, roles are inflexible, communication is unsupportive and there is persisting dependence on the 'ghost'.

These exploratory notions suggest the mechanisms whereby family functioning might affect the grief outcome of individual members.

The inconsistent results of family intervention studies cited earlier demonstrate that we are far from understanding which grieving families need professional help, and moreover, the optimal type of treatment. Longitudinal studies are needed here in order to observe how families grieve in the wake of the death of a family member. Can a typology of patterns be delineated? If families at risk of pathological grief could be identified, then suitable preventive interventions at the family level could be devised and tested to elucidate their therapeutic effect.

Several other topics warrant our attention in the context of family grief. Of a more anthropological nature, ethnicity and religious affiliation, for instance, both probably exert important influences on the family grieving process. The social status of the family is also likely to be significant. However, from a clinical viewpoint, we surmise that the issues discussed above are the most relevant.

Acknowledgements

We thank Julie Jones, John Buchanan, Maria Posterino and Dorothy Richardson for their constructive comments on early drafts of this paper. Our gratitude to Kathleen Madden, Pauline Ng, Carol-Anne Paul and Julie Larke for their secretarial help.

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(*First received November 1992, final revision October 1993, accepted November 1993*)