7

Death: The Most Troublesome Family Secret of All

LORRAINE M. WRIGHT
JANE NAGY

"The only thing that really dies is death."

—Anonymous

"Let us accustom ourselves to regard death as a form of life which we do not yet understand."

—Maurice Maeterlinck

DEATH IS THE MOST troublesome family secret of all. Death does not elude any family member of any race, color, or creed. Death shows no mercy for age. Death can come suddenly, unexpectedly, or after long anticipation. But death never gives the hour of its arrival; it is always a secret. Death invites family members to keep its secret hidden; to live as if dying is not part of living. Death challenges and confronts every belief about life. But death is weak in its ability to prevent humankind from mourning, grieving, and fearing its arrival. Such is the experience of families facing a life-shortening illness. A life-shortening illness invites families to live being afraid of dying rather than to live being united against the secret of death.

How can health-care professionals deal with the secret and mystery of death with families who are experiencing a life-shortening illness? This chapter presents one approach, namely Systemic Belief Therapy, to dealing with the deadly secret of death.

CONTEXT FOR CLINICAL PRACTICE

Family Nursing Unit

The context for the clinical work that is described in this chapter is the Family Nursing Unit (FNU), Faculty of Nursing, University of Calgary. The FNU is an outpatient education and research unit devoted to the interactional study and treatment of families experiencing difficulties with health problems (Wright, Watson, & Bell, 1990). Families experiencing difficulties coping with a life-shortening illness are often part of our clinical practice. Therefore, we have had a variety of experiences dealing with the secret of death. We wish to emphasize that working with families experiencing impending death has not become easier over the years. However, through the process of working with these families, we have developed greater respect and appreciation for what it means to live with the knowledge of impending death. We attempt, within our own clinical nursing team and with the families with whom we work, to deal openly with the mystery and secret of death. In doing so, we have witnessed some very courageous efforts by families to stand up to death, expose it, and deal with the secret of never knowing when death will come.

SYSTEMIC BELIEF THERAPY

The Therapy Model

Systemic Belief Therapy, conceived, developed, and practiced at the Family Nursing Unit, focuses on the interaction between the health problem and family members' beliefs about the health problem (Wright & Simpson, 1991; Wright & Watson, 1988; Wright, Luckhurst, & Amundson, 1990; Wright, Watson, & Bell, 1990). One main assumption underlying all our clinical work is that *the belief about the problem is the problem*. This assumption is very similar to the first-century philosopher, Epictetus. He wrote that "men are disturbed not by things, but by the views which they take of things. Thus death is nothing terrible, but the terror consists in our notion of death, that it is terrible. When, therefore, we are hindered or disturbed, or grieved, let us never impute it to others, but to ourselves—that is, to our own views" (Higginson, 1948, p. 19).

When families present at the FNU, efforts are made to invite new beliefs or views of the health problem, in order to broaden the range of solution options. Distinctions that both families and health care professionals make about "health" and "illness" are believed to be subjective judgments made by observers about this adaptation (Maturana & Varela, 1992). We are con-

cerned with understanding the recursive interactions between health/illness and family beliefs. We respect that each family should function the way that they desire and in a way that they determine is most effective. As part of a larger system, however, the FNU team members recognize that they are bound by moral, legal, cultural, and societal norms that require them to act in accordance with those norms regarding illegal and/or dangerous behaviors.

Through the medium of therapeutic conversations with families, we draw forth beliefs through the asking of questions by *both* client and interviewer (Wright, 1990). Families coevolve an ecology of beliefs, which helps each of the individuals to define cognitions, behaviors, and emotions. During the assessment phase, we attempt to elicit each family member's beliefs about the etiology, treatment, and prognosis of the illness. In addition, we assess their beliefs about control of the symptoms associated with the illness. Beliefs shape the way families adapt to life-shortening illness. Following the assessment, the therapist makes distinctions between constraining and facilitative family beliefs.

Constraining beliefs arise from social, interactional, and cultural contexts. Constraining beliefs inhibit the autonomy of the individual and the family by restricting options for alternate solutions to problems. Constraining beliefs may be challenged by health-care professionals introducing new connections between beliefs and behaviors, which may draw forth facilitative beliefs from family members. Change occurs when there is a shift in the constraining beliefs. The family's ability to change depends upon their ability to alter their beliefs about the problem.

Efforts are made also to assess any constraining beliefs held by the therapist that may hinder a family's ability to deal with the secret of death. Health-care professionals are confronted about their own beliefs about immortality when a life-shortening illness presents itself. Impending death also challenges our professional beliefs about our ability to alleviate suffering and grieving. In both the family and treatment systems, the "meaning" assigned to death becomes paramount. Prior to middle adulthood, few people think about their own deaths. Pattison (1977) suggests that serious consideration of death constitutes projection of "a trajectory of our life." A life-threatening diagnosis, a "crisis knowledge of death," changes the family life trajectory. As this life trajectory is changed, our innermost beliefs about life and death are confronted and challenged.

BELIEFS ABOUT DIAGNOSIS

Both the nursing and medical professions have been given the privileged power of making diagnoses. However, a diagnosis only becomes meaningful in an interactional context. A diagnosis is an interactional event that occurs

when one person (the medical or nursing professional) assigns a classification to another (the identified patient) (Glenn, 1984). At the time of diagnosis, the patient, family, and health-care system enter into a contract regarding the health problem. Among the most powerful implications of a life-shortening diagnosis are the patient's and family's beliefs about it. Unfortunately, health-care professionals too often do not seize the time of diagnosis as an opportunity to begin a discussion about death. Frequently, health-care professionals have colluded amongst themselves and made decisions that families should not be informed about the possibility or inevitability of death. This presumptuous behavior is based, in our opinion, on health-care professionals' belief that families will find it too emotionally burdensome to deal with the knowledge of impending death. In our clinical practice we have experienced quite the opposite. Families find it *less* troublesome to deal with the knowledge of a life-shortening illness and consequently *impending* death when we deal more frankly about our inability to predict the *time* of death. Unfortunately, impending death often invites health-care professionals to behave as if they know death's secret, i.e., when the time of death will occur.

However, there does exist a trend by health-care professionals to be less constrained and to inform families of the prognosis of impending death. Perhaps to be even more helpful as health-care professionals, we need to give our professional judgment regarding prognosis in a manner that focuses on living rather than on trying to ascertain the time of death.

Our clinical team has witnessed both small and major miracles with families experiencing life-shortening illness as they deal more openly with the prognosis of *impending* death and the inability to *predict* the hour of death. By being more explicit about the secret of death, that is, that *no one* can predict the time and hour of death, we begin to demystify death. We must emphasize to our clients and their families that they are entitled to life as long as they are living. We must also emphasize that prognosis is based on clinical expertise and medical science; it is not based on an objective knowledge of when death will occur. When the secret of death is no longer kept hidden in family conversations, new and different interactions may take place between family members, which may facilitate the healing of wounded relationships. When families engage in new conversational experiences, they may find they appreciate a "quick" death when there has been great physical pain, or they may be thankful for a slow death when there has been emotional pain, in order for emotional healing to occur.

Just as each person's grief is unique, so is each person's *anticipation* of loss. The anticipation of loss is a functional response, usually related to how other family members are preparing for it. Thus, one family member's denial may be more a relational than an intrapsychic phenomenon.

To appreciate more fully our clinical approach to assisting families who are confronting death, we present the following narrative:

ONE FAMILY CONFRONTS THE DEADLY SECRET OF DEATH

Frank, the grandfather in the Watt Family, called the FNU to make the first appointment and identified that the presenting problem was the experience of sexual abuse of his grandson, John. From age three to 11, John was sexually abused by his stepfather's cousin. McGoldrick (1991) suggests that it is not surprising, because of denial of death in our society, that many clinical cases involve loss even when it is not the presenting problem. John is presently living with his grandparents, Alice and Frank. John's mother, Anne, is a 37-year-old homemaker married to Bob, who is 35 years old and unemployed. Anne and Bob have been married for 12 years and have one child from their union, Kevin, age 12. Anne has two children from previous relationships, Peter, age 20, and John, age 16. John and Peter have minimal contact with their biological fathers.

Our Clinical Work: The Beginning of the Story

John attended the first session with his grandparents, Alice and Frank. Alice inquired if the sessions were confidential as, "John's parents don't

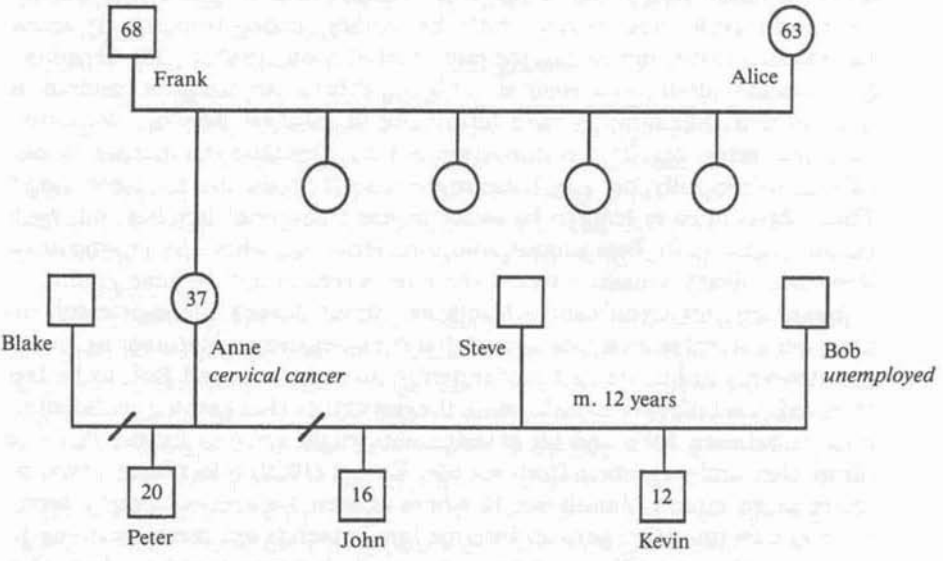

Figure 7.1

know that we are here." John added that he wanted to keep the sessions a secret from his mother and stepfather because "they won't feel like they are part of my life and besides I don't want mom to worry." Our clinical nursing team then learned that John's mother, Anne, was diagnosed seven years ago with cervical cancer. Anne recently had a re-occurrence of the cancer and had been extremely ill. Several significant beliefs surfaced regarding the impact of Anne's illness on the family. John stated that: "Mom's cancer and her pain has destroyed our family." The prognosis of Anne's illness, which had not been discussed among family members or with health-care professionals, emerged as another "secret" in the family.

In our clinical work with families, the phenomenon of health-care professionals not discussing the prognosis with the patient and/or family members is a common occurrence. Family members have their own beliefs, which may have been influenced by the medical system about the length of life, but death remains the ultimate secret. By asking circular questions, the interviewer sought to explore the impact on John of his mother's illness (Tomm, 1988). John related that he frequently felt sick to his stomach and found it difficult to concentrate at school.

In families experiencing a life-shortening illness, there is an increased likelihood of emotional and/or physical symptom development when family members are unable to openly discuss the impending death (Herz Brown, 1989). Even though parental roles are much less differentiated than in past decades, a mother's terminal illness at this stage of the family life cycle has different implications than a father's. "Disturbance of archetypal nurturance and security relationships with the mother creates deep anxiety about future satisfaction and care in the family" (Bahnson, 1987, p. 38). Terminally ill mothers often feel despair at not being able to care for their children. It is important that families with terminally ill mothers develop alternative nurturant resources. This is important not only because the mother cannot fill that role as fully, but also because she herself needs care or "mothering." These shifts in roles tend to be easier in less traditional families, but each family discovers its own unique solution. However, when the prognosis of impending death remains a secret, these resources cannot be generated.

Based on this significant information about Anne's life-shortening illness, our clinical team hypothesized that the extensive involvement of John's grandparents in his life had inadvertently invited Anne and Bob to be less involved in his life. We wrestled with the possibility that keeping the sessions a secret between John and his grandparents might serve to further distance his mother and stepfather from his life. Karpel (1980) refers to this type of secret as an internal family secret where at least two people keep a secret from at least one other person. Internal family secrets can create or strengthen boundaries and alliances within the family between secret-holders. Our

clinical team decided that as the Watt family had firm beliefs that were organizing their behavior in regards to who presented at the family sessions, our clinical team would be less directive and invested in who attended sessions. Through Systemic Belief Therapy, we hoped to challenge some of their beliefs in an effort to influence the other key family members to participate in the sessions.

In exploring the circumstances of how John had come to live with his grandparents, it was revealed that Anne and Bob had had an abusive and violent relationship throughout their marriage. John believed that his mother's illness was related to the continual marital conflict between his mother and stepfather.

This belief of John's is also held by our clinical research team (Wright, Watson, & Bell, 1990) through our study of the relationship between illness and family dynamics (Watson, Wright, & Bell, in press; Wright, Bell, & Rock, 1989). We believe that our ontogenic history (all of the past structural changes that occur throughout our history of interactions) is as equally significant as our phylogenic history (genetic or evolutionary history) (Maturana & Varela, 1992). However, it is within the domain of family interactions that we have an opportunity to intervene by facilitating conversations of affirmation and affection among family members (Wright, 1991). Maturana (personal communication, October, 1988) offered the following poignant comment about this connection: "The only thing that I know is that love is a fundamental emotion in human beings. And I consider the most human diseases, most human suffering arises from interference with these fundamental emotions."

John's grandparents believed that their grandson did not need confrontations with his parents on a daily basis and that their daughter was too sick to be a mother to him. John's move to live with his grandparents was viewed by our clinical team as an attempt to distance himself from the emotionally charged situation of his mother's life-shortening illness and his parents' constant fighting. We also wondered if John and his grandparents were attempting to protect Anne and preserve her strength because she was presently very ill.

Herz (1980) suggests that when facing a life-shortening illness, families will attempt to reduce emotional tension. In the Watt family, the lack of discussion regarding Anne's prognosis was creating emotional and even physical distance between John and his mother. Herz (1980) believes that the degree of disruption to the family system dealing with a life-shortening illness is affected by four major factors: "1) the timing of the serious illness in the life cycle; 2) the nature of the serious illness; 3) the openness of the family system; and 4) the family position of the seriously ill family member" (p. 224). Applying Herz's perspective to the Watt family would indicate a

high degree of disruption. The life-shortening illness of John's mother is occurring at a time in the life cycle that does not follow the normative course of life. "The timing is off; it is out of sync" (Herz Brown, 1989, p. 464). When a serious illness occurs in family members who are in the prime of their lives, the experience can be *the* most disruptive to the family (Herz Brown, 1989; Rolland, 1990; Wright & Leahey, 1987).

During the first session, the therapeutic conversation also centered around John's experience of sexual abuse. John had disclosed his "secret" to his grandfather in the week before their first therapy meeting. John had previously received treatment for the sexual abuse when he was 12 years old, but Frank believed that treatment had been inadequate. Frank was also very concerned and upset that he had not been told earlier about the sexual abuse that John had experienced as a child. He could not understand why John had kept this secret from him for so long. During the session, it was learned that Alice had always known about the sexual abuse, but had never shared the secret with Frank.

At the end of the first session, it is a routine part of our practice to ask each family member the "one question question" (Wright, 1990) i.e., "If you could have only one question answered through our work together, what would that one question be?" John responded by asking: "Who am I? Once I tear down the wall I have built up, how do I keep it down?" Alice and Frank responded with, "What can we do to help?" We believe that soliciting questions from clients often reveals their constraining or facilitative beliefs and their most pressing concerns that may otherwise go overlooked. As therapists, we can only ask what we know to ask. By inviting clients to ask questions of us as therapists, we are taken into another domain of clients' belief systems.

At the end of the first session, Alice and Frank were commended by our clinical team for the caring, respectful, and nonjudgmental attitude that existed among the three of them. John also was commended for his openness and was told that, in the opinion of the team, he had been both tyrannized by illness and betrayed by an adult. We agreed with the family that there were many issues to pursue; betrayal by an adult in the form of sexual abuse and the impact of a life-shortening illness on the family.

The Middle of the Story

In the third session, John came by himself. He informed us that, after our last session, he had initiated a talk with his mother about his strained relationship with his stepfather. John stated: "I started to think about the situation from my dad's perspective." The therapeutic conversation from the previous session appeared to have influenced John to consider a new view.

We explored John's new perspective about his stepfather by asking, "What will this new view of Bob invite you to think or do differently?" John responded that he would talk differently to him and go over and visit more. Very quickly, John proceeded to discuss the issue most pressing for him: "Everyone believes I have so many problems. My only problem is having everyone worry about me. Grandpa drives me crazy because there is always something about me that he wants to fix. Ever since I told grandpa about the sexual abuse, suddenly I became a teenager that really needed help." John had a desire to live with his grandparents, but to lead his own life.

In the next session, Alice wanted to come on her own. Again, although our clinical team believes that systemic work can be accomplished with only one family member present, we struggled with the family's desire to have members seen individually. We were concerned that the pattern of seeing family members individually might serve to increase the potency of the secrets. However, our clinical team decided to let the family direct both the pace and direction of change (Wright, Watson, & Bell, 1990), of which one aspect was who would come to sessions.

Alice relayed the news that her husband, Frank, had been hospitalized for a cardiac condition and that Anne, her daughter, was receiving radiotherapy to shrink the tumour in her pelvis. Alice listed a great many things that John did with which she and Frank did not agree. The impact of John's behavior on Frank and Alice's life was explored. Alice stated that she thinks it is "too big a job to look after John" and that she is "too old for this." Alice expressed that they rarely showed their anger or disappointment in John's behavior, because they did not want their home to resemble the hostile environment that he experienced at his parent's house. It is interesting to note that the fact that his grandparents were not pleased with John's behavior was kept a secret from John. The team introduced the idea that it seemed that there were many different people interested in parenting John. Distinctions of parenting and grandparenting were made by our clinical team. We offered the opinion that "we would recommend taking a holiday from parenting for the next few weeks and focus on grandparenting. This may help you get through the next difficult weeks with both Frank and Anne in the hospital." Our clinical team hoped that our opinion would serve to promote Alice's facilitative belief of becoming more of a grandmother to John and less of a mother. Alice responded that she had been thinking about being more like a grandparent to John and less of a mother. It is this alternative view which may shift a family's outlook and increase the variety of responses possible in a situation.

In session five, Alice and John arrived at the session together looking relaxed and happy. John reported being left more on his own to make his own decisions. Alice reported that she had felt more like a grandmother, but

that she was not in agreement with some of the decisions that John had made. She believed that a 16-year-old was just too young to have free rein.

Frank, who had recently been discharged from hospital, came to the sixth session with two main concerns. First, he was concerned about the relationship between John and his daughter, Anne. Mother and son were fighting a lot, and John appeared to be angry with his mother much of the time. The therapist focused on exploring Anne's role in John's life and the family's beliefs about that relationship. Frank believed that John thought his mother was going to die shortly. Frank believed also that Anne would like to be more involved in John's life. The interviewer asked Frank, "Is there a belief in the family that Anne is too sick to deal with concerns about John?" Frank stated that was indeed the case. However, he further stated that Anne had a lot of insight and empathy for John. The team hypothesized that John's belief that his mother was going to die soon perpetuated his desire for distance from the family. The increased conflict between John and his mother enabled them to keep distant from one another. We believed that it was not only the knowledge of impending death but also the secret of the actual *time* of death that propelled the need for more distance. Recursively, the more difficulties that John experienced, the more Anne attempted to be close to him. Her behavior may also been driven by her beliefs that she might not have long to live and that John needed her help.

Herz Brown (1989) suggests that the intensity of long-term illness is hard to deal with on a continuing basis because of the difficulty in maintaining a balance between living and dying. Often, when the family and the dying individual attempt to protect each other from anxiety, they stop communicating. The lack of communication creates tension and distance, which can be manifested in a variety of symptoms. "The longer and more intense the family stress is, the more difficult it is for the family relationships to remain open and the more likely it is that dysfunction will develop" (Herz Brown, 1989, p. 473).

In this session, the reflecting team (Andersen, 1987) was utilized to offer the idea that it would be beneficial to include Anne in John's life and in our sessions. Frank commented that he could now "see" that Anne had been a missing part of the sessions and that he would approach his daughter and ask her to attend the next session. Finally, the team would have the opportunity to meet John's mother who, despite her absence, had been a powerful presence.

The Turning Point of the Story

In the seventh session, the team had the opportunity to meet Anne. She came by herself to the session, and our clinical nursing team was immediately struck by her frail appearance and her tremendous desire to help her son.

She eagerly reported that "I wanted to be in on this counselling because our family needs help, John needs help, and I need help in helping John." We now felt that with the presence of Anne in the sessions, a context for change had finally been created.

Anne expressed concern that her son had lost interest in everything. Anne believed that John must be angry at her for being sick for so long. She also believed that not knowing *when* she was going to die was the most difficult thing for John to handle. While Anne was explaining her perspective she became tearyeyed. When the therapist explored her related affect, she replied, "I am feeling worried and guilty about John because of my husband and I—we have really messed him up." At the end of the session, our clinical team commended Anne for her concern, insight, and empathy for John. The team validated Anne's perspective as being valuable and offered the opinion that John could be experiencing extreme fear and grief in response to Anne's impending death. Anne felt that she would like to return with John for a session the following week.

The Climax of the Story

Indeed, mother and son came to the next session together. During this session, we learned that one of John's school friends had been killed in a car accident. As well, he had recently left high school because he found it too difficult to concentrate. John described his friend's death as the "straw that broke the camel's back." He told the team how depressed and hopeless he felt when his friend died. "His death showed me that I could lose everyone. But I am feeling much better now because I realize that I have supportive friends who care about me and that I like myself. I also know mom is worried about me, but I just want her to know that I'm okay."

Providing an opportunity to discuss an impending family member's death can be a significant intervention when working with families experiencing a life-shortening illness. The discussion may facilitate the release of new information into the family system helping the family to face the impending family member's death (Wright & Leahey, 1987). Herz Brown (1989) believes that the life-threatening illness of one family member can allow the family, if the system remains open, to resolve significant relationship issues.

In exploring John's understanding of Anne's prognosis, the team learned that John had found the secret of not knowing his mother's prognosis was the most difficult aspect for him to handle. "When you have no clue, you feel like your life is being played with. I'd rather mom died, I could accept that." The uncertainty and the secret nature of the time of death is, for many families, more difficult than the death itself. Toward the end of a long illness, it is not unusual for the dying individual and the family to wish for death (Herz Brown, 1989; Rolland, 1990).

Anne raised her concern that she did not feel a part of John's life. The therapist sought to understand if John believed that his mother was too ill and would feel too burdened if he shared more of the stresses of his life with her. John agreed that he thought his mother was too ill to handle his problems. His stepfather had recently reinforced this belief by telling John not to worry his mother because she was "too sick to cope."

The therapist explored ways that Anne could be more involved as a mother in John's life. The conversation quickly deteriorated into one of accusations and recriminations (Wright, 1991).

JOHN: I know you want me to move home, but I can't, it's like an emotional holocaust. There's problems everywhere, between you and Dad; you are sick; Dad feels guilty because you are sick, and no one is happy with me and who I am. I don't want you involved in my life.

ANNE: (sobbing) I realize that it's too late to have the kind of family that I always wanted. There's too much bitterness, anger, and hatred. I had just hoped that we could work on putting our family back together.

JOHN: I feel totally guilty.

Suddenly, John asked to leave the room. While he was out of the room, the therapist took the opportunity to inquire whether Anne was feeling as worried as she had been at the last session about John's behavior. Anne reported that, from her perspective, John's behavior had improved.

When John returned to the session, the urgency he felt to tell his story was evident. The conversation gradually shifted to one of mutual affirmation and affection.

JOHN: What am I supposed to do? You are sick and I know that you want to have the family that you've dreamed about. But should I put myself back into an emotional holocaust? I don't want to get messed up again. But, at the same time, my mom is sick, and I love you. What if you die, how can I live for the rest of my life knowing that the one thing my mom wanted never came to be?

ANNE: You are right John, I don't think you should come home. I'm crying because of my own personal guilt about the past, not because our family isn't together and you won't come home. I don't blame you.

As the session progressed, John and Anne began to bridge the emotional and physical distance that had existed between them. John shared with his mother how pleased he was about the reduced conflict between him and his stepfather and that he felt closer to his family now than ever before. John also wanted his mother to know that "I am fine, and I've turned out well."

The therapist then asked Anne if there was anything that she would like to say to John. Anne told John how impressed she was with his thinking and that he knew a lot more about what he was doing than she had previously realized. John tenderly responded by reaching out and taking her hand.

A major transition occurred in the session when John spontaneously reframed their past sorrows.

JOHN: Another way to think about our life, Mom, is that if none of this had happened, we would not be the same people that we are today.

ANNE: I hope that we can use all the garbage that's gone on to our benefit rather than let it destroy us.

JOHN: The way I look at it, Mom, I am like a piece of coal, and through all the pressure it becomes a diamond.

The therapist entered the conversation, again by asking John and Anne what they had come to appreciate about each other and what their hopes were for the future. John commented that he appreciated his mother's strength and the way that "she really fought for our family." John hoped that, in the future, Anne would remember that he loved her and that he was okay. Anne also expressed that she hoped John would know how much she loved him. She also hoped that they would be able to have a better relationship in the future because of all that they had learned about each other during this session.

Reflections on Our Clinical Work

In the first several sessions, John's grandparents believed that John's problems were related to his early childhood experience of sexual abuse. However, as the sessions progressed, it became apparent that John's primary concern was the lack of control over his life related to his mother's illness and prognosis. The uncertainty of his mother's chances of survival produced his fear of impending death. Once the inability to predict the secret of death was verbalized, it allowed a healing process to begin between mother and son.

The underlying beliefs that were driving particular family members' behaviors took time to identify and conceptualize. The other secrets that were operating within the family had to be addressed before the secret of death could be confronted. Change, which Bateson (1972) describes as "difference which occurs across time" (p. 452), happened very gradually throughout the sessions. From our previous clinical experience of working with families experiencing a life-shortening illness, this is not an uncommon occurrence.

To stand up to the secret of death takes tremendous courage and tenaciousness. A dramatic story was unfolding.

A significant transition point in our clinical work was the use of a reflecting team (Andersen, 1987), which challenged the constraining belief that Anne was too sick to be involved directly in John's life. The reflecting team is a powerful intervention as it allows family members to assume a metaposition to their situation and provides them with a reflection of their beliefs. If the alternate perspectives, beliefs, and opinions offered by the team are relevant for the family, they will select an idea that can influence them to view their situation in a different way. The idea offered by the reflecting team fortunately influenced Frank to entertain the possibility of Anne being involved in further sessions. Our clinical team believed that Anne was the critical missing family member. Once Anne became involved in sessions, a significant turning point had been reached and a context for change was created.

We view health problems as interactional dilemmas derived from family beliefs. Family beliefs organize family behavior. Anne's belief that she was responsible for John's problems, and John's belief that his mother was going to die and his emotional turmoil resulting from not knowing *when* she would die, created an interactional dilemma of mother and son inadvertently distancing from each other. The secret nature of Anne's prognosis, and the fact that the family had not discussed it, intensified the interactional dilemma between mother and son. The life-cycle stage of this family also contributed to the interactional dilemma as the primary developmental task of adolescent separation conflicted with the anticipated loss, which requires families to move emotionally closer to support one another (McGoldrick & Walsh, 1991). The poignant and beautiful healing session with mother and son was facilitated by the therapist providing a context in which conversations of accusations and recriminations were altered to conversations of affirmation and affection (Wright, 1991). As the conversation between Anne and John shifted to one of affirmation and affection, it was evident that Anne was entertaining a new belief about her son, that he was "okay." As well, John's recognition of the pain and guilt that his mother felt about the past, as well as the love she had for him invited new facilitative beliefs about his mother. By altering Anne and John's beliefs about each other, new stories were created about their relationship and themselves. When new stories are created, old beliefs are refuted.

John's metaphor of the coal becoming a diamond was a poignant vehicle through which he was able to express what was previously inexpressible. By making the implicit explicit, John and his mother were able to begin the healing process. Further, John's metaphor about himself was hopeful as it implied that he was beginning to answer his question from the first session, "Who am I?" It was the team's hope that the open communication that had

been re-established between John and his mother would help him to keep down the wall he had built around himself.

Rolland (1990) suggests that making peace with self and family is a fundamental task in coping with threatened loss. Unresolved issues of blame, shame, or guilt can seriously compromise movement towards healing relationships. "Threatened loss, by emphasizing life's fragility and preciousness, provides families with an opportunity to heal unresolved issues and develop more immediate, caring relationships" (Rolland, 1990, p. 242). However, we feel that the secret of death is *the* controlling factor in a family's ability to face the impending loss of a family member. Once family members can stand up to death, then there is the opportunity to be united against its secret.

With regard to the future, the team wondered if the change in the relationship between John and his mother would influence other relationships in the family. Also, now that Anne had come to believe that John was all right, would her death come more quickly? At the time of the writing of this chapter, Anne continues her courageous effort towards surviving. Her time of death continues to be a secret.

CONCLUSION

A life-shortening illness of a family member is a highly emotional and challenging experience. Our clinical work with the courageous family described in this chapter indicates the role of constraining beliefs surrounding the interaction between family members and their secrets, uncertainty and loss of control around a life-shortening illness, and more importantly beliefs about death. Systemic Belief Therapy focused on identifying those beliefs that were constraining and providing alternate facilitative beliefs for the family's consideration. Alternate beliefs were introduced in the form of interventive questions by the therapist *and* family members, opinions of the clinical nursing team, and the use of a reflecting team. With the caring context provided by our clinical nursing team, mother and son were able to stand up to the secret of death and begin to heal their relationship. Through assisting families to unite against the secret of death, we have observed immeasurable courage and faith in families as they face one of life's greatest challenges: the challenge of living with the knowledge of dying.

> Who never mourned hath never know,
> What treasures grief reveal,
> The sympathies that humanize,
> The tenderness that heals.
>
> —Anonymous

Postscript

Anne's time of death is no longer a secret. She died "peacefully" three months after the completion of our clinical work.

REFERENCES

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process, 26*, 415–428.

Bahnson, C. B. (1987). The impact of life-threatening illness on the family and the impact of the family on illness: An overview. In M. Leahey & L. M. Wright (Eds.), *Families and life-threatening illness*. Springhouse, PA: Springhouse Corporation.

Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballantine Books.

Glenn, M. L. (1984). *On diagnosis: A systemic approach*. New York: Brunner/Mazel.

Herz, F. (1980). The impact of death and serious illness on the family cycle. In E. A. Carter & M. McGoldrick (Eds.), *The family life cycle: A framework for family therapy*. New York: Gardner.

Herz Brown, F. (1989). The impact of death and serious illness on the family life cycle. In B. Carter & M. McGoldrick (Eds.), *The changing family life cycle: A framework for family therapy* (2nd ed.). Toronto: Allyn & Bacon.

Higginson, J. W. (1948). *Epictetus, the enchiridion*. New York: Macmillan.

Karpel, M. A. (1980). Family secrets: I. Conceptual and ethical issues in the relational context. II. Ethical and practical considerations in therapeutic management. *Family Process, 19*, 295–306.

Maturana, H. R., & Varela, F. J. (1992). *The tree of knowledge: The biological roots of human understanding*. Boston: New Science Library.

McGoldrick, M. (1991). Echoes from the past: Helping families mourn their losses. In F. Walsh & M. McGoldrick (Eds.), *Living beyond loss: Death in the family*. New York: W. W. Norton.

McGoldrick, M., & Walsh, F. (1991). A time to mourn: Death and the family life cycle. In F. Walsh & M. McGoldrick (Eds.), *Living beyond loss: Death in the family*. New York: W. W. Norton.

Pattison, E. M. (1977). *The experience of dying*. Englewood Cliffs, NJ: Prentice-Hall.

Rolland, J. S. (1990). Anticipatory loss: A family systems developmental framework. *Family Process, 29*(3), 229–244.

Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask lineal, circular, strategic or reflexive questions? *Family Process, 27*, 1–15.

Watson, W. L., Wright, L. M., & Bell, J. M. (in press). Osteophytes and marital fights: A systemic approach to chronic pain. *Family Systems Medicine*.

Wright, L. M. (1991). *Therapeutic conversations: From accusations to affirmation*. Unpublished manuscript.

Wright, L. (1990). When clients ask questions: Enriching the therapeutic conversation. *Family Therapy Networker, 13*(6), 15–16.

Wright, L. M., Bell, J. M., & Rock, B. L. (1989). Smoking behavior and spouses: A case report. *Family Systems Medicine, 7*(2), 158–171.

Wright, L. M., & Leahey, M. (1987). *Families and life-threatening illness*. Springhouse, PA: Springhouse Corporation.

Wright, L. M., Luckhurst, P., & Amundson, J. (1990). Family therapy supervision as counter-induction. *Journal of Family Psychotherapy, 1*(3), 65–74.

Wright, L. M., & Simpson, P. (1991). A systemic belief approach to epileptic seizures: A case of being spellbound. *Contemporary Family Therapy: An International Journal, 13*(2), 165–181.

Wright, L. M., & Watson, W. L. (1988). Systemic family therapy and family development. In

C. J. Falicov (Ed.), *Family transitions: Continuity and change over the life cycle* (pp. 407–430). New York: Guilford.

Wright, L. M., Watson, W. L., & Bell, J. M. (1990). The Family Nursing Unit: A unique integration of research, education and clinical practice. In J. M. Bell, W. L. Watson, & L. M. Wright (Eds.), *The cutting edge of family nursing*. Calgary, Canada: Family Nursing Unit Publications.