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AUTHOR Williams, W. Vail; And Others
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ABSTRACT

This paper describes an ongoing research project which is designed to test the effectiveness of crisis-oriented social systems intervention as a model for primary prevention with bereaved families. The families' immediate reactions to the death and their subsequent reorganization are discussed in light of two factors: (1) the interaction pattern that exists between the family and the larger social system; and (2) the interaction pattern that prevails within the family system itself. Observations to date have suggested that the degree to which a family will accept and benefit from outside intervention at the time of a death is a function of its incorporation of the norms and values of society into its own familial value system. In addition, the type of systems coping patterns employed by the family, as well as the role the deceased had assumed within the family system, have been found to be critical variables that influence the course of bereavement and subsequent readjustment. Data obtained from the second paper supports the contention that the behavior of bereaved individuals does progress through various stages of grief, and that readjustment of the family depends greatly on the role of the deceased prior to his death. (KJ)

THE REACTIONS OF FAMILY SYSTEMS TO SUDDEN AND UNEXPECTED DEATH [1]

Rita R. Vollman, Ph.D., Amy Ganzert, Lewis Pitcher, Ph.D.
and
W. Vail Williams, Ph.D.

Fort Logan Mental Health Center
Denver, Colorado

This paper describes a portion of the clinical material gathered from the first year of a four-year research grant* studying the application of crisis intervention techniques to bereaved families as a means of primary prevention. The hypothesis of this study is that intervention at the time of a sudden death will reduce the higher morbidity and mortality rates found by other workers (e.g., Rees and Lutkins, 1967) to occur in the surviving family members.

The focus of the present paper is to discuss some of the concepts that have evolved during our work with bereaved families. These concepts have given us a line of vision which makes clear the kinds of aid that can be offered; that will be accepted; and that will, hopefully, prevent further disorganization in these families which are already in crisis.

Specifically, the discussion centers around the interactive patterns between the family and society which determine whether or not the family is open to intervention, and the variables operating within the family itself that affect its immediate reaction to the death as well as its eventual reorganization.

What we do not discuss other than by implication, but what is our main working assumption, is that families are more than the composite blood or

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marriage related group that can be counted in fixed terms. Rather, we see the family as a dynamic entity - constantly in flux - accepting and rejecting, as the need arises, such diverse members as the minister, the mother-in-law, the babysitter, the doctor, etc., (Polak, 1970). It is this natural group of people with whom we do our work.

The families we see are identified through an arrangement established with the coroners of Denver, Arapahoe, and Jefferson counties. Those families, who consent to participate in the research project, are being randomly assigned to a Crisis Intervention Experimental or a No-Intervention Control Group. An additional matched group of families who have not experienced a recent death will serve as a No-Crisis Control Group.

Those families who have been assigned to the experimental group are contacted by the intervention team within at least 12 hours after the death. Usually, the team accompanies the medical examiner on his routine call to the home of the surviving family members. If the family agrees to participate in the study, they are seen for two to six sessions over a period of one to ten weeks, with the total family or social system being involved in the treatment. This short-term intervention is aimed at increasing the effectiveness of the family in coping with feelings, decisions, and subsequent adjustment related to the death.

Recognizing that there are many inherent problems in the evaluation of a broad-action program, such as the present study, assessment is being geared more toward a field approach whereby the focus is not simply to test the hypotheses already formulated, but to suggest new ones as well. Thus, the assessment instruments were designed not only to obtain standard measures of outcome, but also to get at qualitative and process-oriented data. The

general areas chosen for evaluation are: (a) medical illness; (b) psychiatric illness; (c) family functioning; (d) crisis-coping behavior; and, (e) social cost estimates. These areas will be measured six and eighteen months after the death for families in the Crisis Intervention Experimental and No-Intervention Control Groups. For the No-Crisis Control Group, the measures will be taken at initial contact with the families and again one year later.

To describe assessment procedures and data collection might seem presumptuous when one stops to consider the problem of entry by strangers into a family system at such a critical time as the event of a sudden and unexpected death. This problem gives a good illustration of the necessity of keeping in mind the fact that, just as an individual can be viewed as part of a family social system, the family must be seen as part of the larger social system. How a family incorporates societal values into its own familial value system has implications for its success or failure in readjustment after the death.

We have found our work to be most effective with those atomized, nuclear families, who are accustomed to the idea of professions and experts from whom they willingly accept advice and support. These families have very direct lines to the "mass society" through its organs of communication and its accepted interactive patterns. They are club members, social churchgoers, and Life magazine readers, who conform enthusiastically to the expressed Weltanschauung of middle America. In the absence of the closely knit kin network of fifty years ago, they have their club and professional organization memberships; in the absence of neighborhood assistance, they hold considerable insurance against sudden need or tragedy; in the absence of grandmother's homilies on child-rearing, they have Hiam Ginott; and in the absence of strong family traditions around death, they are open to

expert intervention. The mortuary initially provides this professional guidance and sets norms. Its implicit messages include: "The 'body' is not to be touched"; "Be quiet - decorum is to be maintained"; or, "Experts are essential to the process around death - to prepare the body, to properly bury it. You are unqualified in this area - defer to us." "To fulfill societal expectations," they say, "these things must be done." And they generally are, regardless of the emotional or monetary cost to the family. In the event of suicide, this family is never more vulnerable. Suicide, being unacceptable in the pervasive Judeo-Christian ethic, is seen as bringing shame to the family; and, as a result, natural mourning evoked by the loss is effectively blacked and superseded by guilt. Anger, which is normally veiled and only symbolically expressed in the larger cultures to which they are finely attuned, likewise remains unexpressed. Further, anger toward a dead person is widely felt not to be legitimate and is only experienced with great discomfort.

These families, though eminently well-prepared financially in many cases for death, are profoundly unprepared for its emotional impact. The topic of death brings up a vague disease which comes from a leery attitude toward aging and an aseptic approach to the body. Death is the opposite of unblemished skin, white teeth, and regular bowel movements. The vast inexperience and overrefined sensibilities around the physical aspects of death precludes, in many cases, coming to grips with the emotional reality of eventual or immediate loss. These families, it seems, in the absence of secure and deeply-ingrained patterns of coping with real-life crises and in a situation where their cultural norms are minimal or inefficient, contradictory, or even nonexistent, have a battery of professionals on call to make right what

otherwise would remain a raw and painful wound. The families have, in other words, a "contrived" social system from which semi-symbolic gratification of needs is provided on a new model - functionally suitable, it appears, to current societal reality. Since they trust "experts," knowing that they themselves are competent in only one or perhaps two fields, we are most cordially accepted into the "contrived" social system in which they move, and have, in fact, been able to give much aid in terms of emotional support, advice, practical help, and guidance, but we have always had the feeling that they would have obtained other aid without much trouble had we been unavailable. These people are the successful "converters" of our culture.

There are, of course, families in the aforementioned group who interact a great deal with the larger social system but who do not become mirrors of it. They are able, on the one hand, to become aware of the cultural norms and values around the area of death, but somehow are able to assimilate only those values consonant with the goals and priorities of the family system and to discard the others. On the other hand, this pattern of open but selective interaction makes many support systems, such as religious and fraternal organizations, friends and neighbors, etc., available to the bereaved family and permits it to make successful use of these resources.

With families who are part of a cohesive cultural subgroup, our success has been less than overwhelming. In contrast to the families mentioned above, we have been intimidated by the sheer number of mourners, by clearly competent friends and neighbors, and by the ease and grace with which these families function at the time of a death. We have found ourselves ornamental, at best, and awkward, isolated bumblers, at worst. We have been impressed with the fact that, in these families, children are not shunted aside, but carry on in their usual loosely supervised and irrespressible manner - wailing, laughing, playing,

or whatever. We have seen that the body is not isolated (nor referred to as the "body"), but is rather touched and wept over freely. We have seen emotional needs met swiftly as they occur. It seems that families who are members of a cohesive subculture are clearly closed to the mass society, in terms of their supreme inability to adhere to the larger norms and values around death. Yet, in their small subculture, their exist norms which most adequately serve needs arising during a crisis of this sort, which allow for extreme expression of grief or anger, and, in general, accept feeling. In this natural structure comprised of family, friends, and neighbors, death becomes again what it once must have been - a highly functional rite of loss and grieving - which in its immediate despair and disorganization is a deep confirmation of life and of the necessity of human cooperation.

There is still another group. These families are atomized and nuclear, but interact neither with contrived nor natural social systems which might be called on for help in time of need. They have no club memberships; no huge kin system; no ministers; no bridge parties; and no neighbors who are known to them, even though there are people living on each side of them. In general, they have minimal social contact. They are tied up in their family exclusively, and any outside interests are regarded more as an intrusion than a pleasurable diversion. These isolates have every chance of incurring the physical and mental breakdown seen possible among survivors after a death. These families, with such meager resources, can bankrupt themselves in time of tragedy. It is our hunch that these are the families who need aid and support more than any others, and the task is difficult. Their resistance to outside help is as great as their need.

It would appear then, in general, that the degree to which families allow for and benefit from outside intervention is a function of their incorporation of the norms and values of the larger society into their own familial value

system.

Up to this point, we have directed our attention to different ways in which two social systems - the family and society - interact, and the effect this has on how a particular family will respond to a death, as well as that family's willingness to accept and make use of outside intervention. Our focus will now shift to an examination of processes within the family that influence the course of bereavement and subsequent readjustment.

We have found that families with open internal communication systems are more prone to resist the societal taboos surrounding the area of death and are thus more likely to discuss and make realistic plans for the death of their members. A family who consistently deals with stress by attempting to assess and absorb the reality components of the situation rather than by trying to deny them is certainly able to cope more effectively with the immediate crisis which a sudden death precipitates. The degree to which it is permissable to express feelings of sadness and loss, as well as the less-acceptable reactions of anger, guilt, and relief, seems to play a larger role in determining the success of the readjustment period.

These types of coping patterns are examples of some variables of internal organization within the family system that affect the way it deals with the sudden and unexpected death of one of its members. Our experience to date has shown, however, that the single most important factor in the reorganization of a family, as an ongoing social system following a death, is the role the decedent had been assigned, and which he assumed within the family system.

The resumption of adaptive functioning following a death is facilitated in a family where vital roles and functions have been apportioned among members in a just and equitable manner for optimal comfort and satisfaction in their performance. This type of apportionment occurs when roles are assumed according to individual need, ability, and potential. In such a case, role assumption

is usually explicit and well understood by all family members. When a member of this type of family dies, the critical period of reorganization is not likely to be experienced as a crisis because the family already has a built-in process which allows it to reallocate the role functions of the decedent with minimal difficulty.

No matter how equitable and explicit the role distribution in a family system, the exact number and type of roles held by the decedent influence the degree of difficulty experienced by that family in its attempts at readjustment. For example, in comparison to a child, an adult assumes primarily instrumental or task-oriented roles. Some of these, like that of the bread-winner, can be troublesome and time-consuming to reallocate if the skills necessary to fill that role are not available among the surviving family members. On the other hand, the death of a child, while precipitating a lengthy and intense period of emotional stress, usually does not necessitate an extensive period of role reorganization, since children have roles that are primarily expressive or socially-emotional in nature.

This is not to imply that expressive roles are easier to redistribute or that they can be left vacant for longer periods of time without repercussion. The death of a family member whose role was essentially expressive can oftentimes lead to disaster, particularly if the function of that role was to camouflage or resolve a conflict existing within the family system. Take the death of the child again, for example. If the child should have served the need for distancing between the parents or, conversely, the need for a catalyst to stimulate otherwise dormant feelings in order to keep the family emotionally extant, his death would severely tax the family's already inadequate resources to deal with the stress and would provoke further disorganization and maladaptive behavior.

Expressive roles, particularly those that encompass some type of deviant or unacceptable behavior, are usually assumed on the basis of much more ambiguous criteria than something like age or sex. A role can be classified as deviant either by the particular norm system of the family or by the one that the larger society employs. When the family member who dies is the one who was always a little different from the others, the one who never quite fit in, the phase of readjustment will be relatively brief and minimally stressful. This is because the decedent, prior to his death, had already been extruded from the family system and had held a role perceived by the family as nonfunctional, in terms of its own value system. Often it is the deviant, as defined by society, who plays a dysfunctional role in the family. Alcoholics, for example, sometimes become not only useless to the families in the sense of having ceased to provide either tangible or emotional support, but also become a liability in terms of draining family resources and provoking community censure. Their deaths demand little, if any, need for role reallocation in the family and often engenders a sense of relief.

At other times, however, rather than being dysfunctional, the alcoholic, the suicide attempter, or the hysteric - any symptomatic person, in fact, performs one of the most vital role functions for the maintenance of the entire family structure. That crucial role is to symbolize and represent a disturbance in his family social system. The death of that person sets off a process in the family parallel to symptom substitution in the individual. Symptom substitution has been described by some as the replacement of one set of behavior, thought to express or represent some inner conflict, by another set whose function is identical. This phenomenon occurs when the inner conflict is not resolved, but the symbolic representation of it in behavioral form is discouraged or extinguished in some manner.

A similar process has been observed in the family social system. Many family therapists have documented the spontaneous development of symptoms in one family member when those of another member have shown remission during the course of treatment. When the symptomatic member of a family dies, however, his role is not quite so easily redistributed. His family system, already by definition functioning in a precarious and faulty fashion, will be forced to undergo an extensive and painful period of readjustment which, if unsuccessful either in terms of reassigning his role or working through the original systems conflict, will eventuate in the collapse of the system.

This paper has described an ongoing research project which is designed to test the effectiveness of crisis-oriented social systems intervention as a model for primary prevention with bereaved families. We have discussed these families' immediate reactions to the death and their subsequent reorganization, in light of two factors - the interaction pattern that exists between the family and the larger social system, and the one that prevails within the family system itself. Our observations to date have suggested that the degree to which a family will accept and benefit from ourside intervention at the time of a death is a function of its incorporation of the norms and values of society into its own familial value system. In addition, the type of systems coping patterns employed by the family, as well as the role the decedent had assumed within the family system, have been found to be critical variables that influence the course of bereavement and subsequent readjustment.

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CRISIS INTERVENTION IN ACUTE GRIEF[1]

W. Vail Williams, Ph.D., Paul Polak, M.D.
and
Rita R. Vollman, Ph.D.

Fort Logan Mental Health Center
Denver, Colorado

In spite of increasing interest in primary prevention for mental health programs, there has been a dearth of controlled experimentation testing whether primary preventive programs do, indeed, prevent anything. Furthermore, crisis intervention techniques have been suggested as a basis for primary preventive programs. Caplan (1964) has suggested that mental health professionals can significantly influence the mental health of the community by consulting with natural care-givers, such as ministers, doctors, and police, in order to facilitate crisis resolution leading to growth. The main assumption is that positive resolution of natural life-crises tends to decrease the risk of mental illness and social disorder in the population.

This paper describes a clinical research project in its second year of operation at the Fort Logan Crisis Unit which is designed to test the hypothesis - that primary preventive intervention around the specific crisis of sudden and accidental death can actually decrease the risk of psychiatric illness, medical illness, and social disturbance experienced by families exposed to the crisis.

One of the major initial problems in systematically testing this assumption was the difficulty in defining the crisis state. By selecting sudden and unexpected death as the life-crisis, it was felt that Bloom's (1963) definitional criteria of the crisis concept were most clearly met. Sudden and unexpected death was seen as a severe, irrevocable stress which impinges

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on families and family members, necessitating basic structural alterations in the organization and functioning role of family members in every instance. In addition, families who have recently experienced a sudden or unexpected death in the family show an increased risk of higher morbidity and mortality rates occurring within the first year after bereavement (Rees and Lutkins, 1967; Parkes, 1969). As a result, we felt that sudden or unexpected death could reliably be assumed to be a crisis within the family system in every case.

In keeping with the overall hypothesis, the following specific hypotheses are being tested:

(a) Close relatives who have been provided with therapeutic crisis intervention will show evidence of more adaptive coping behavior than bereaved relatives who have not been exposed to the therapeutic intervention.

(b) A group of bereaved relatives who are exposed to intervention will exhibit a lower incidence of medical illness, and/or psychiatric illness, and/or disrupted social functioning as compared to a group of bereaved relatives who received no intervention.

(c) A group of close bereaved relatives is more likely to develop mental illness, medical illness, and/or disturbed social functioning than is a group of family members who have not experienced such a recent sudden death.

METHOD

The project follows a 3x2 repeated measures design. The first factor involves three groups, an experimental group receiving crisis intervention following a recent sudden death, a control group I receiving no crisis intervention following a recent sudden death, and a control group II having no recent death and receiving no intervention. The second factor involves two time periods when assessment measures will be taken - six months following the death and again at eighteen months.

SAMPLE: Approximately one-hundred bereaved families from the Denver Metropolitan Area are being randomly assigned into two groups, the experimental group and the control group I. An additional group of approximately fifty families or relatives which have not experienced a recent death within the family for at least one year prior to contact will serve as a no-crisis, no-intervention control group II. All groups are matched for age, socioeconomic status, education, and family size.

PROCEDURE: One of the major innovations of the present study is the fact that the project intervention team is able to provide immediate interventive assistance, usually within one hour after the death and often involving notification to family survivors in cases of sudden or unexpected death. This arrangement is made possible with the cooperation of the Denver Metropolitan County Coroner's Office. The project intervention team attempts to use a social systems interventive approach whereby the clinician acts less as a professional and more as a natural resource person to the family system. The clinician works in the background of the system and fits his assitance into the natural social structure of the family he works with. Usually the initial session is open-ended and may last from one to six hours. Finally, families are usually seen over a six-week period involving five to six sessions. At the same rate that families are included in the experimental group, additional families are collected from the coroner's current files in order to make up control group I. These families will not be contacted until six months after the death of the decedent. Finally, prospective families for control group II are randomly selected from locations similar to those of families in the experimental and control I groups. These families will be evaluated upon initial contact and again at one year from the initial contact.

EVALUATION AND ANALYSIS OF DATA: Recognizing that there are many inherent problems in evaluating a broad action program such as the present project, evaluation was geared more toward a field approach whereby the focus is not to simply obtain measures but to learn as well. By utilizing a systems theory approach, the evaluator is alerted to the need to identify forces which are mobilized by the introduction of the program, as well as to assess the impact of intervention on the grieving family, and changes and stresses on the family system, as well as how much freedom of movement the interveners were allowed in the family. Thus, assessment instruments were designed not only to obtain standard measures of outcome but to obtain qualitative and process-orented data as well. The general areas for the outcome measures are: (a) medical illness, (b) psychiatric illness, (c) family functioning, (d) crisis-coping behavior, and (e) social cost estimates. These outcome measures will be taken at six months and eighteen months after the death of the decedent for families in the experimental and control I groups. For the control II group, the measures will be taken upon initial contact with the families and again one year later. In the areas of medical and psychiatric illness, a psychiatrist will be making ratings on each family for degree of symptom formation and impairment.

The analysis of the data will involve two different levels of assessment, the individual as a unit and the family as a unit. In any event, analyses will proceed through comparisons of the experimental group to control group I. In addition, comparisons will be made between the experimental and control I groups and control group II which is providing "base rates" for incidence of illness. Finally, multi-variate analyses will be carried out in order to determine those variable which best distinguish normal grievers from abnormal grievers. Also, detailed analyses will be made on the process and qualitative data in order to determine what kind of impact the present project had upon the systems and subsystems mentioned previously.

PRELIMINARY RESULTS: One of the first critical questions for an action program such as this was would bereaved families accept a professional service of this type. Our initial impressions were, that with the project intervention team arriving approximately one hour after the death and that the families being normal families, our rejection rate would be 50%. It was felt that this 50% acceptance rate should be welcomed. However, as of this date, results are well above the initial impression - 70% of the families approached have accepted the service, 22% refused, and 8% were not available. This finding is similar to that found by Gerber (1969).

It should be kept in mind that the preliminary results mentioned here are based on pilot cases where limited clinical impressions and empirical data have been ascertained. Based on these data, two important trends have emerged. First of all, if the decedent's role prior to the death was to be the scapegoat for the rest of the family, then extensive and painful reallocation of roles is needed after the death. If the reallocation is unsuccessful, the family system tends to collapse. That is, the reorganization of the family as an ongoing social system, following the death of one of its members, is primarily a function of the role that the decedent had assumed within the family system. Furthermore, the more healthy the roles of the family members, prior to the death of one of its members, the greater the likelihood the family system will have many more resources or support systems from which to get help. On the other hand, a more maladjusted family system tends to deny the reality of the death, block any show or discussion of emotional reactions, and is more isolated and unable to make use of available support systems. Secondly, in such cases where the decedent's role prior to death was to be a generator of conflict, such as being an alcoholic and/or demanding too much from other family members, family members after the death of the decedent reported feeling that

their behavior had improved in terms of closeness within the family system, emotional tone, decision-making, and social adjustment. That is, it appears that the individuals who had died had been placing a burden upon their respective families which had inhibited normal family functioning. These reports were supported by the fact that 14% of the bereaved individuals felt they had a better social adjustment after the death than prior to the death. In addition, 25% of the surviving children reported that their behavior and emotional tone had improved.

Data obtained from the pilot testing of the standard measure of outcome, as well as from interviews, supports the contention that the behavior of bereaved individuals does progress through various stages of grief (Averill, 1968; Bowlby, 1961). Even though bereaved individuals progress through the several stages of grief, 90% felt that the worst was over during the first week. Furthermore, based on physical and psychiatric health data collected six months after the death from six pilot families (twenty-three individuals), three of the families revealed that at least one family member was having difficulty in adjusting. That is, these individuals showed a higher percentage of somatic complaints, depressive symptoms, and psychiatric disturbances. In each of these families, tragic sudden death had occurred. Finally, data obtained from a family functioning measure showed that those individuals who were having a difficult time adjusting were perceived as more distant and withdrawn by other family members.

Overall, it will be interesting to see if these trends and suggestions found in the pilot phase of this project will hold up after completion and analysis of all data at the end of the project. In addition, in testing the effectiveness of crisis intervention as a model for primary prevention, it is hoped that the results of the present study will serve as one guide for the

strategic use of the time and money in the prevention of medical and psychiatric dysfunctions. Finally, it is felt that findings and techniques from this project would benefit not only mental health professionals but would be of significant importance for community members and support systems as well.

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