



Facing Death: Family Therapy Narratives and Intergenerational Echoes

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This paper reflects on the nuanced way in which the therapeutic dialogue establishes a safe space for families to address and give meaning to mortality and the different ways in which they hear, understand, and communicate about impending death. Intergenerational patterns of families responding to and navigating a terminal diagnosis are also considered. Language, the therapist's own narrative and experience, familial and intergenerational experiences as well as meanings of life-threatening illness are explored. The concept of impending death as *haunting* is introduced and explored. Adding this 'existential' haunting into the formula allows us to consider that impending death offers as an opportunity to 'unblock' communication between and within families and at the same time to identify 'blocked' communication patterns, thus providing a deeper understanding through an elucidation of rifts between family members and/or developing unexpected possibilities for movement and reconciliation.

Keywords: death, grief, intergenerational patterns, haunting, narratives, illness

Key Points

1. The paper reflects on the impact of a terminal diagnosis and how to best support families therapeutically through this experience.
2. Family therapy can create a safe space for each family member's story about the person who is or may be dying, and, where appropriate, for the terminally ill person to share their private knowledge in a supported space.
3. A family therapy approach can provide a safe and meaningful space to deal with distress during a critical moment in time and creates opportunities for family members to be supported and have their different views heard.
4. The process of reflection and dialogue in writing this paper has helped to elucidate critical elements as we 'walk the road' with families facing a diagnosis of a terminal illness.
5. An existential distinction between grief and haunting/hovering affords a deeper connection with systemic and narrative concepts in terms of making sense of one's life and death and its complex ecological system.

This paper is an extension of an earlier publication where we engaged in a dialogue around 'the experience of illness in families and the concomitant reflections on how best to therapeutically support families through those experiences' (Tisher & Nichterlein, 2018, p. 243). It is written by the same authors and uses a similar methodology to the one of that paper: that of a dialogue between these authors (where Miriam is *Jill* and Maria is *Jackie*). Following a fine Batesonian tradition of exposition through dialogue (Bateson, 2002; Bateson & Bateson, 1987), the use of dialogue enables reflection and unpacking of different elements at play in a case example. It is also an extension in terms of the themes explored – health and illness – pushing them to

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their limits in terms of life and death. In pushing these themes, this paper transforms the quality of the dialogue, adding a vivid awareness of what we would like to call 'existential intensity' in the treatments of the themes treated.

Miriam, the first author – Jill for the purposes of this paper – is a clinical psychologist and family therapist with more than 50 years of experience and is one of the directors of a family therapy centre where specialised training is also offered. Jill has also been involved in providing training programs and supervision to psychologists, GPs, and family therapists in settings including aged care and a specialised cancer hospital. Maria – Jackie for the purposes of the paper – has close to 40 years of experience as a counselling psychologist and as a family therapist in different countries and has worked in different clinical settings including a specialised cancer hospital.

This paper is the result of our increasing interest in the experience of families where a family member faces a terminal diagnosis and the concomitant reflections on how to support families best therapeutically through this experience.

Rycroft and Perlesz (2001) note that grief and loss have had sporadic attention in the family therapy literature and make reference to Walsh's (1991, p. 57) statement: 'The subject of death is the last taboo in the field of family therapy.' Niall Williams (2014) writes: 'Only through story can we tolerate death.'

Dialogue

Jill: It is now my time to present a case for consideration.¹ In line with our interest in the dynamics of health and illness, it might be useful to "turn the heat up" a bit and touch on issues of life and death, of life when facing death. The case example I am presenting is a composite one and constitutes the experience of many clients with whom I have worked. The consolidation of cases in this way preserves client anonymity within this example but still permits structural and relational patterns to be identified. The identified patient is "Sue." A senior oncologist referred Sue to me. The oncologist explained: "I would be grateful if you could see Sue and help her. She has terminal cancer and is struggling to accept this. She is not eating; she is depressed and is living a miserable life. She says her husband and children think she can still beat this cancer and recover but, according to the scientific information at hand, they are unrealistic and possibly making it worse for her and her family. Sue is 58 and has been unwell for some 18 months." The oncologist is clear that Sue is in terminal stages of her cancer and that she will not recover. I suggested Sue be invited to call me to discuss the next step. When Sue called me, she was very keen to come and see me as soon as possible, as she knew she had little time left and she was worried about her husband and their three adult children who were living independently. In line with my usual practice, I took some family history during this conversation and asked whether her partner/husband or other family members knew she was making contact. Sue said her husband knew that she was calling me. I then asked her if she would prefer to come on her own or whether she would like to invite him to come with her. She was clear that she would prefer to come with him. I then asked if Sue thought her husband would be okay to attend and she said yes. I invited her to make a time for them to attend together. My approach in this first contact reflects a systems/family therapy perspective in a generic sense: noting the importance of the system and including – or seeking to include – relevant family members if at all possible. If this is not possible, at least to check out the attitude and impressions of the client vis-a-vis the likely attitude of relevant family members. This is distinct from working in the more traditional "identified patient" approach where the client who seeks help remains the client;

rather than inviting the client to consider including other family members in the therapeutic process and having the family not the individual as the “identified patient.” Sue and Peter attended the first session. Sue was grateful to be in the room, but Peter looked uncomfortable. Peter said he did not see the point – he was confident that the treatment would work, and that Sue would be fine. He said Sue was unnecessarily negative and that he was confident that the oncologist (in whom he had absolute faith and confidence) was going to be able to access the appropriate chemotherapy treatment for her to recover. Sue smiled sadly at Peter and asked him to hear her out.

Jackie: What a powerful presentation of an issue that haunts the clinic. Haunting seems to be an appropriate word. Two of the definitions for ‘haunt’ in the *Shorter Oxford English Dictionary* (2002, p. 1205) describe this appropriateness at two levels. As the dictionary states, when talking about “a ghost, a spirit, etc.,” haunt means “visit frequently, with manifestations of its presence” and, when talking about “a thought or feeling” it means “occur to or affect frequently, esp. as a cause of trouble.” Both these meanings seem pertinent because the presence of death is a ghost in the therapeutic room, a ghost in as much as it is never materially present but ever hovering. The therapeutic space is inhabited by life, by people actively involved in the process of making sense of and affirming life through an active engagement with the riddles and dilemmas that such life brings forth. Death presents itself then, not as an affirmative presence in the therapeutic room, but as a ghost or a spirit. And yet, even when it is not “materially there” – or, as Derrida (1978) would say, it is deferred – it strongly informs life. Here we move to the relevance of the second definition provided by the *Oxford Dictionary*, the one that pertains to thoughts and feelings. Here, “haunt” is relevant since death often presents itself to the psychological life of an individual, quite understandably, through fear and apprehension. This is something that we take for granted: we want life, and we avoid/are anxious about/afraid of death. It takes a rather counterintuitive move to start to appreciate other relationships with mortality. Here, we have much to learn from existentialist traditions within psychotherapy (Frankl, 1946/2020; May, Angel, & Ellenberger, 1958; Yalom, 1980; and more currently, Bazzano, 2021 and Heidenreich, Noyon, Worrel, & Menzies, 2021). These traditions base their practices in existential philosophical ideas, ideas that – starting with Kierkegaard (1980) and Sartre (Priest, 2001, see also de Beauvoir, 1947/2004) – argue that it is by engaging with the limitations of our own mortality that we can aspire for a deeper, more real, authentic and meaningful connection with our lives. A more recent and “close to home” version of these ideas can be seen in the reflections of Depraz (2002) on Varela’s own considerations on his mortality during the late stages of his cancer.²

Jill: I appreciate the language and concepts that you have introduced. The haunt/haunting is a wonderful term for the imminent and ever-present “hovering” of death in the presence of a terminal diagnosis or indeed for many people who experience anxiety without clinical morbidity or, simply, fear about death. Is it possible that both for Sue and Peter the haunting was present but articulated through different expressions? Sue impressed me as being in the process of coming to terms with the limits of her life and the inexorability of her death, an inexorability that made the haunting very real. Perhaps also, to use your language, she was engaging with the limitations of her mortality, aspiring for more real connection with her life. For Sue, there was a need not to avoid or deny the haunting, or her mortality, but to look at it with open eyes, to talk about death – her death – and prepare for it. Given her preparedness to face death, Sue was able to focus on life – on life after her death – by focusing on how Peter and her children would cope with both her dying and life thereafter. For Sue, the haunting of death was no longer a threat but became a strange yet familiar element in her life, making the possibility or likelihood of death approachable. For Peter, on the other hand, the haunting was intensely uncomfortable, unfamiliar, overwhelming, and scary. Peter appeared to manage the haunt of Sue’s death by “pushing it away,” “fighting it,” or

“negating it.” Following Williams (2014), Sue was able to tolerate death – she had a story that made it tolerable for her; Peter was not yet able or ready to tolerate Sue’s death – for him there was no story except that “it would not happen.” This was my understanding in this first session. The words spoken by Sue suggested an acceptance of her situation and that she was seeking to bring Peter on this journey with her and perhaps to help him (and her children) face her reality. Thank you for introducing the image of impending death as a “ghost” or “haunting presence” in the therapeutic space. The therapeutic language and concept usually invoked in the psychological and family therapy literature where death or impending death is considered is *grief*. Yet grief takes us to a very different conceptual landscape. Grief is generally about loss, about something that is already gone. The term “grief” is used in so many situations – grief for culture lost when relocating, for loss of job or financial security, for family breakdown, for loss of connection with family and friends in pandemic lockdown, for loss of physical and mental function, and, of course, for loss of family or friends in anticipated or sudden death. If grief was to be applied to the situation we are discussing, it would perhaps refer us to the loss of the “confidence” that the individual, couple, and family unit had about their living in the present and preparing for the future, short and long term. It also refers to the impending absence in the physical world of a valued family member. Grief refers to loss of what we have and perhaps also to fear of impending loss and how one will manage this or fall apart in its face. For Sue, grieving for the loss of her future; for Peter, grieving for Sue’s possible impending death and associated losses for him and their family. Haunting is indeed an appropriate concept for facing death and associated conversation and emotion.³ The interrelationship between haunting and grief is important.

Jackie: Thank you, Jill, for helping in articulating further this nuanced yet very powerful distinction between “haunt” and “grief” when facing death. As you say, grief pertains to the domain of loss – even anticipated loss – of a life *after* the loss of someone (or something) loved. In this sense, grief looks to the past, and the effects of the past in one’s life. Such a loss has an effect on oneself but, by definition, refers to a loss of someone (or something) else. The haunting, on the other hand, brings us to the limits of one’s own existence. In this sense, the haunting is a much more intimate and intense experience, an experience that plays with the present and the future. And it plays with these times by defining and informing ethical questions as to how we want to live our life. Another way of conceptualising the interplay between grief and haunting may be through the use of the homeostasis concept in systems thinking. With grief and haunting comes a powerful sense that the stability of relationships and the trust in those relationships is being threatened. As Barboza, Seedall, and Neimeyer (2022) suggest, “families find themselves in constant transition after a significant loss as they search for a ‘new normal’ and rebuild homeostasis” (p. 11).

Jill: Your framing brings to mind Rycroft and Perlesz (2001) who noted that the therapist “needs to communicate her or his capacity to sit with strong feelings and to deal with issues of blame and ambivalent feelings” (p. 62). The therapist’s narrative about death matters and is likely to influence the capacity to create the safe space that is needed and to be able to witness the intimate and intense feelings associated with facing death. Is it then possible that, when facing death, when facing the presence of the ghost or of the haunting presence of death, *grief is not the whole story*? Could it be that – using existential conceptualisation – we should be attentive to the possibility that, in the language and narratives inhabiting that space when individuals and families are preparing for death, there might be growth and illumination alongside the grief? Is there value for considering that, where death is anticipated and where there is some time to talk and adapt, there is also time and opportunity for meaningful conversations, for “goodbyes” and for preparation for the next stage for the family as well as for the death process of the ill individual? That the confidence in the stability of the system is being shaken and there is fear about the unknown of the next stage?

Jackie: I fully agree with your points. Looking at facing death not just through grief but in its interplay with the haunting we have been speaking about, changes the orientation of the therapist gaze, allowing not only to a deepening in the work to address what “really” matters but also to an enlarged and, I would dare to say, spiritual affirmation of life. It is in the midst of these considerations that the dilemmas that Sue and Peter brought to your meeting with them present a clear example of the power of a systemic perspective. Facing death – individual death – is not just about coming to terms with loss but opens the space for a more profound and intimate affirmation of life. Facing death is neither a private affair in the same way that living and dying are not private affairs. We – humans – are social animals in life, including during its most dramatic time when facing death. In moving these “existential” considerations into a systemic gaze, the haunting of death enters into play with and in the narratives of all relevant as players calling for a new balance or homeostasis to be conceptualised by the family. In many ways, this search is perhaps enabled by the therapist in a respectful way, by implicitly having confidence in the family’s capacity to find such a new balance through validating the fears that accompany or haunt this process.

Jill: As Weingarten (2000) writes, the capacity of the therapist to “witness” death, thus increasing the opportunity for clients to die a “good death,” is a function of the therapist’s training, belief systems, and health system expectations. Medical technology has a mandate to keep clients alive (perhaps at any cost), a mandate that can conflict with the acceptance and witnessing of death. Unlike chronic illness which may or may not directly affect us as therapists, death certainly will and we need to be aware of our reactions, belief systems, and assumptions. Each person has a history of witnessing death and of its associated rituals. Within families, there may be more than one model for the experience of death and, in a socio-cultural sense, there will be rituals associated with their specific ethnic background(s), religious beliefs, and the possible presence of traumatic death events. The experiences and family histories present in different members of families may complement each other or may clash . . . and there are many shades in between. It is common for each partner of a couple to have different approaches/experiences/rituals/beliefs about diagnosis of terminal illness, medical intervention, and openness of conversation. In times of high stress such as terminal diagnosis, these different approaches can be very distressing and conflicted. The therapist will also have their own history. An important role of family therapy is to create a safe space for each family member’s understanding or narrative or story about the person who is or may be dying, and, where appropriate, for the terminally ill person to share their private knowledge in a supported space.

Jackie: I totally agree with you Jill. I believe that witnessing the facing of death by a family is one of the most intense experiences we – as therapists – need to learn to face. And this has to do with the level of vulnerability that this topic brings forth. The ethical question of how to affirm life in the midst of its closest encounter with death witnesses not only the most humane moments within the clinic but also could bear witness of its most iatrogenic moments (Nichterlein, 2013a).

Jill: Perhaps this is a good point to go back into Sue’s and Peter’s story. In terms of the knowledge available to me, the views of the oncologist and of Sue concurred and the view of Peter stood in stark difference. Having said this, being able to stay neutral in the face of different narratives is a key point of all family therapy. The challenge is to create a safe space where more than one narrative can co-exist and be respectfully heard – including the view of the expert treating medical practitioner as family members communicate that to me. As I understand it, Sue was seeking to communicate her private knowledge to her family and to me. Peter’s interpretation was different, perhaps to manage his, Sue’s, or the family’s anxiety. The first session impressed me as though Sue felt understood, but Peter may not have. Peter seemed uncomfortable – as if he is being forced or invited to face Sue’s “negative

thinking” or “anxieties” about her condition. Sue, on the other hand, looked relieved to be in the room and hoping that she could be heard through this process and, perhaps, also hoping that Peter might be supported through the pain she believes was ahead of him. Towards the end of the first session, I invited both Sue and Peter to reflect on how this session was for them, on any questions they may have and on whether they would like to continue. Sue responded instantly saying yes; Peter was more equivocal but agreed. Both agreed that the oncologist was an excellent practitioner in whom they both expressed full confidence. The content of the discussion in this first session was led by Sue: it was her energy that had brought them to family therapy and her situation that was labelled as life-threatening and urgent. If this had not been the case, there may have been space for other issues in the family to be identified as relevant also, for example, the history of their relationship and other stressors. The way the session progressed, the agenda of this session, was very much Sue’s. When they both agreed to return, albeit Peter reluctantly, a step forward had been taken. The aim was to move slowly, reflecting both parties’ views and understandings, and prioritising the creation of a safe space. The content and the “veracity” of their different opinions and views was less important for me than nurturing a sense that they were both feeling supported.

Jackie: Indeed a big step forward has been taken in the process by you allowing them to articulate their differences in terms of the haunting prognosis. As with other presentations, at the core of systemic work is helping families to recognise the multiplicity and complexities of perspective that constitutes a rich family experience. This compass is not lost when facing death. Your work afforded the creation of a space for both voices to be stated, where each of them was open for consideration. What strikes me of the work you did is that, in setting the scene for the therapeutic work, there was no denial of the tragic circumstances that informed the referral. The words of the oncologist, that both of them respected - although only one of the perspectives at play – provided a frame to the materiality present in the work, the materiality of our bodies; a materiality that informs the constraints of our life (and death) shaping the challenges and our capacities to deal with existential angst. From this awareness, there is indeed something somewhat “light” in social constructionist approaches, a lightness that focuses only on the celebratory aspects of diversity and of possibility, finding it hard to articulate the heavy burden of mortality. There is no doubt that the big epistemological turn of the 1990s that saw family therapy developing an acute awareness to the constructive function of language, provided the field with significant and powerful insights and tools. But, in some ways, this new appreciation also obscured and neglected the “material” conditions that inform and frame the possibilities of play at hand. It is then not surprising that there has been a compensating turn – *the material turn* – in the social science that looks into extra-discursive elements at play in the articulation of life: not just epistemological concerns relating the way we construct knowledge but also physical and material elements that inform the kind of knowledge we can access (i.e., the type of eyes we have) and the discourse in which our narrations take place.⁴ There is an ironic dramatic element in lightness that emerges out of the absence of consideration of the material elements of life, an irony that is best expressed by the novelist Milan Kundera (1984): *The heaviest of burdens is therefore simultaneously an image of life’s most intense fulfilment. The heavier the burden, the closer our lives come to the earth, the more real and truthful they become. Conversely, the absolute absence of burden causes man to be lighter than air, to soar into heights, take leave of the earth and his earthly being, and become only half real, his movements as free as they are insignificant* (p. 5). Although both Sue and Peter have clear opinions as to Sue’s condition, it is central to recognise that Sue’s condition was not a matter of negotiation. The cancer was “real” and so was its advanced state. In order to support them in being able to face death in a way that would open up the possibility of a better quality of what remained of Sue’s life, therapy needed to hold both: on the one hand, the need to

create space for both perspectives to be present in the dialogue and, in the other, it also needed to address the tragic circumstances of this process. The oncologist knew this as you did. This became the central frame for the work to be done.

Jill: Thank you for your perspective here. As you say, finding language and story for overwhelming experiences is an ongoing challenge for the therapeutic space and for life itself. At the same time, whilst I have admiration for Kundera's writing, I am troubled by the idea that one needs "heavy burden" to become more real and truthful. Having said that, it may be that, faced with imminent death, Sue was enabled to confront and share her inner "demons." Perhaps, and re-visiting the last paper we wrote previously (Tisher & Nichterlein, 2018), the facing of imminent death is the "crack which allows the light in" (Cohen, 1992). Little cracks are often easy to dismiss and may become invisible to our eyes. But, as clinicians, if we are open to noticing these cracks and clarifying with clients whether they also see them, the crack can indeed "let the light in" and enable a therapeutic process.

Having this in mind, let me move to the second session.

The Second Session

Sue opened the second session by stating how much better she had felt since the last session and articulated her sense of relief, gratitude, and appreciation of Peter agreeing to continue. She said she knew it was challenging for him. Peter sat quietly and said he had come for Sue.

Sue then launched into her experience of her father's death many years earlier, when she was a teenager. She said she was not told of her father's illness, that it was cancer, and that he was dying. She was not allowed to see him when he was dying. Her family culture was one where death was not spoken of. Indeed, she said, she had grown up with the belief that talking about death was likely to bring it on and that, if the ill person was told they had a terminal illness (in this case cancer), this would likely escalate the dying process. Sue cried as she told this story and spoke in detail of the emotional pain that she had suffered as a result of being kept out of the information loop and, in particular, of her not being able to say goodbye to him. She said she often 'talked' to her late father, apologising for not having said goodbye and not being there for him emotionally. She said her mother had been very stoic and, after her father died, had moved forward without much emotion. She could not remember being included in rituals or indeed whether there had been any. She spoke of being overwhelmed by grief and anger. She said she had loved him dearly and her most pressing need was for her children not to suffer as she had all these years. She wanted her children to be able to say goodbye to her and she to them and she desperately wanted Peter's support in this. Now, facing the same situation, she said she was desperate to make it different for her children.

Peter listened quietly and showed sadness with tears and reaching out to Sue physically to comfort her. Sue's expression of feeling took most of the session time, and it felt as though she was reliving and giving expression to a long-held trauma. As is so often expected, she wanted her children to be spared the pain she had experienced. When I invited reflection of the session, Sue expressed relief that she had been able to finally give words to her long-held pain. Peter struggled to give words to his experience of the session but was emotionally in tune with Sue and said he understood what she had gone through. They were keen for another session. It appeared that one

of Sue's agendas in coming for therapy was to share this underlying trauma and grief that she had lived with for so long.

Helpful here is Hedtke's (2014) use of re-membering, of 'generating new meaning and purpose for those who carry forward the stories of the deceased' (p. 12). I became aware of another level of engagement by Sue – that of re-living and sharing her trauma when her father died and her need to give her family a different experience. Again, there was little or no space for Peter's narrative or for any other issues to be raised. Whilst I was aware of this, Sue's agenda was expressed as urgent, and Peter did not seek to raise anything in the space. I was also aware that this couple had a history and shared children and had struggled financially and culturally in Australia.

Jackie: This is a deeply touching session. It is so because it unfolds the complexity of networks inherent to life. Cannot but think on Bateson's (1973) preoccupation in articulation an understanding of mind that was counterintuitive to the move towards "brains"; a mind that instead kept on connecting with older notions of "soul" and "spirits." The title of his famous book – *Steps to an Ecology of Mind* (1973) – talks of this journey, a journey that is central to the systemic gaze. And his last book – *Angel's Fear: Towards an Epistemology of the Sacred* (1987) – talks to this "rhizomic" (Deleuze & Guattari, 1980/1987) network as sacred. A strange language for a scientist to use, yet a very important one to affirm. As I wrote elsewhere: *the sacred for Bateson referred to what was 'peculiarly related to the healthy' (Bateson, 1974, p. 266) and thus . . . should not be talked about or disturbed. The sacred was 'an integrative dimension' (Bateson & Bateson, 1987, p. 2) both of that which is conscious – that is, literal and purposive – and that which escapes definitions – the mysteries in and of life – which can only be comprehended metaphorically, if at all* (Nichterlein, 2013b, p. 69). It seems to me that, if Peter struggled for words, it was because he knew – despite all of his apprehensions – that what Sue was describing was larger than his fears and needed, for the health of the family, to be articulated and affirmed. Not honouring this would have been unhealthy. To follow the homeostasis conceptualisation, perhaps Sue was supporting Peter to face the adjustment that was needed to re-balance – provide a new balance to – the family system.

Jill: Thank you for your suggestion of the subject matter and that it was "sacred" in Bateson's terms. I had not thought of it in this way, but the description fits. I also felt the process was moving faster than I had anticipated and was keen to slow it a little. I was especially concerned about Peter's response and had the feeling that he was being dragged into Sue's reality faster than he was ready. I also had a call from the oncologist, thanking me for my efforts, and advising me of significant improvement in Sue's functioning at their last consultation. Sue had begun eating well and she was positive and looking energised, notwithstanding her significant illness. So my view was that the process was working well for Sue but I was still not sure about Peter. However, it sounded like they were on a good track, and the important thing was to continue to create the safe space for them as a couple. I also find the homeostasis concept helpful – that imminent or possible death is shaking the system up and a new balance will need to be found, with Sue still in the system, but in a different way, always as a mum and partner but no longer physically present. Whilst thinking and writing this paper, and taking into account your suggestions, I am now aware that the first session broadly opened up a safe space for the haunting experience of facing death to be articulated and felt. Death was indeed "hovering," perhaps menacing and difficult to give language to. I would have loved at the time to offer the concept of "haunting." A safe space was created in the therapy room. The second session was different. It opened up old grief and fear of an old script for death being repeated. Through the articulation, witnessed by myself as therapist, of this "yet-to-be-expressed" past grief, an opportunity to create a new script and reduce the haunt of death was made possible. I did not have the language for this

at the time, but I intuitively enabled the process, as I understand it now. This second session turned out to be the critical turning point for this couple and their family. There were several further sessions with Sue and Peter. In the further sessions with Sue and Peter the conversation turned to the language they would use when talking to the children and how to enable them and Peter to hear Sue's wishes. Peter was still saying he expected that Sue would recover, but he was prepared to be respectful of her need to share with her children her hopes that, if she was to die, they would not suffer as she had done when her father was dying. Sue requested a family session with her three adult children, and it was agreed that Sue and Peter would invite them to such a session.

Family Session

They agreed to attend, and a family session was then held with both parents and the three adult children. Perhaps not surprisingly, in the family sessions there was a split. The son heard his mother and expressed appreciation for the opportunity to hear of her experience when her father died. The two daughters were more of the view that this is what happened to her as a teenager, and with her father, they had hopes she would recover. They seemed to have a close relationship with each other and a somewhat estranged one from their brother. They were not ready to accept that she was dying, or to say goodbye, whilst their brother was able to move into this space. A meaningful emotional communication took place between Sue and her son. But the other family members were not engaged in this process. There was palpable tension between the daughters and their brother. It was almost as if the daughters and their father were aligned whilst the mother was aligned with their brother.

Jackie: This is a great example of the systemic principle of ripples in a pond and how to move from the dyad work into the family. In this specific example, facing death has resemblances of opening a secret, daring to talk about what many did not dare to. This opening brought forth the complexity of the family. As we talked earlier, dying – facing death – is not a private activity. Neither is it a lineal activity. It is not “a cognitive topic,” but an existential dilemma that permeates all of our living activities. In this context, the ability to face death with dignity is intimately connected with the ability to live life well, in a milieu of open and loving communications. If this is lacking, these tensions will present in the work. In this case, the tensions Sue and Peter presented initially reverberate in the capacity of their children to accept this tragedy. Here is the coherence of the system at play . . .

Jill: There was visible and high tension between the siblings. Sue was aware of this, and expressed the hope that, after her death, they would be able to reconcile and support their father in the next stage of his life as a widower. Another agenda emerged through these conversations: there was a long history of tension between the siblings. I acknowledged this and, once again, worked towards respectfully – to all parts of the system – creating a space where each family member could be heard. I also gave a context in that, whilst there had been a reported history of sibling conflict, at this time the family were living with a major stress situation which would likely exacerbate prior conflict patterns and possibly create further difficulties between them. The stress of the diagnosis and impending death may rally the family to “cover up” the cracks, at least on the surface, but would foreshadow that further work might be needed to clarify and hopefully resolve the fractured relationships. As so often, the presenting problem was the “tip of the iceberg.” Using Leonard Cohen’s concept of the “cracks” letting the light in, perhaps Sue’s imminent death enabled light to be shone on a number of issues: Sue’s trauma in respect of her father’s death, the feeling of stuckness between her and Peter in talking about her terminal condition, and their children’s

relationship. I would have liked to offer the family the concept of the system being “unbalanced” by the hovering and haunting of death and perhaps open up a conversation about how their family might “re-balance” moving forward. This may have given them an overview and perspective for the trauma they were experiencing, with a light “at the end of the tunnel” – what perhaps Sue was hoping to achieve.

Jackie: Indeed so, facing death – and death himself -- as we have repeatedly commented through this paper, stands not separate from the task of living a life but is inherent to it, informing the styles of life we assume and the consequences of these choices. This is the point stressed by existentialist approaches to therapy who have followed Nietzsche’s conception of life as a tragedy, a complex play with unknown order where we have to make decisions that are authentic, honourable, and “in good faith” for all those involved. Once we appreciate that life and death are but two sides of a same coin, we can appreciate that facing death is a variation of our living: life informs facing death and facing death informs what we do with life. In this case, Sue’s dealing with her mortality brings to focus what is important for her in her life as well as highlighting to her what still needs to be done. The tensions between her and Peter got in the way of her connecting with this very important part of her/their life. Once Peter was more able to listen her, to listen to enough of her wishes so as to make him confront his own distress, the family dilemmas – the dynamics at the next space of the network – were able to emerge in the dialogue. Simultaneously, the news of Sue’s condition had an impact on the ongoing challenges in the current family dynamics, ironically providing the conditions for the emergence of a second-order change. It is in this sense that, facing death, sometimes in itself, becomes a reminder of the importance of prioritising and honouring what is important in life, and families seem to resolve feuds as part of the haunting that they experience. Sometimes they are unable to do so, and this inability makes facing death that much harder. In this sense, therapeutic approaches that focus just on the medical and moral aspects of the process of dying miss a critical point: that dying in peace is necessarily embedded in the process of living a healthy life.

Concluding Remarks

Writing an article using a reflective and recursive conversation about a case offers an opportunity for emerging insights and applications. Such a method partially mirrors peer supervision but the process of writing, referencing literature, and the many revisions over a period of months adds significant depth to the process. As in our previous paper, we offer some pragmatic learnings and applications from this process.

- *Possibilities emerging from working from a family therapy perspective.* The referral was of an individual, and the process offered was from a family therapy perspective. Individual work with Sue may have yielded some similar outcomes in that the therapist could have worked towards assisting Sue to find a way to communicate with her husband and children. We cannot predict the outcome in lineal ways and neither is this a competition of sorts, of individual vs family therapy approach. What we want to suggest however is that the family therapy approach proved to be faster, safer for Sue in terms of finding a meaningful space to deal with her distress during such a critical moment in time, and offered an opportunity for other family members to be supported in their journey. Furthermore, a family therapy approach afforded more complex underlying elements (intergenerational patterns due to unresolved grief, family rifts) to become visible, allowing for a more complex and deeper connection to be achieved for the client and meaningful others.

- *Creating a safe space for different views to be heard:* Sue and Peter had different views about Sue's mortality which resulted in an awkward avoidance that proved problematic during the most testing moment in life: when facing death. The therapist was aware of the paralysis in conversation and emotion associated with this paralysis. Seeing them together and being accepting of both perspectives as part of the process served to reduce the paralysis, allow them to hear each other and find some acceptance and peace on the way.
- *Being aware of family-of-origin beliefs and experiences with death:* Partners bring their unique experiences to the current family dynamics. Creating a space where these points of view can be articulated and heard is critical to unblock the emotional paralysis experienced by all parties.
- *Rifts between surviving family members:* These were illuminated and labelled during the elaboration of this case. In some family therapy processes, such rifts can be followed up, usually after the death of the ill person. In other families, the offer can be made and, as is our experience, sometimes it has been followed up many years later. These rifts can be illuminated by the light from the crack, a crack that is often enlarged by significant life events such as impending death.
- *The importance of language and storytelling:* For Jill, the concepts of 'hovering' and 'haunting' were powerful and enabling. Homeostasis was also an important concept. For both of us, the process of writing this paper has been significant in helping us elucidate critical elements to have in mind as we 'walk the road' with families facing a diagnosis of a terminal illness. In particular, the distinction between grief and haunting/hovering was explicated in existential terms, a distinction that afforded a deeper connection with systemic and narrative concepts in terms of making sense of one's life and its complex ecological system. This approach can be very welcome in situations such as that of Sue and her family.

Conflict of Interest/Funding Arrangements

The paper was written collaboratively and entirely in our private capacity as therapists, and we did not receive support to do this work.

Endnotes

- ¹ The case example and the dialogue refer to situations where people are facing death in the context of chronic or life-threatening illness. Whilst many of the narratives may apply to conversations around suicide or requesting death in the context of significant pain or reduced ongoing quality of life, this paper does not purport to address these situations directly.
- ² Some of these ideas are also present within cognitive traditions in psychology (e.g., Edwards, 1990; Hickey & Mirea, 2012) and in acceptance therapy (e.g., Heidenreich, Noyon, Warrel, & Menzies, 2021; Ramsey-Wade, 2015).
- ³ Death may also be sudden and unexpected – for example, an accident and trauma – where little, if any, preparation is possible. Death by natural events – such as pandemic, HIV, flood, and fire – or by the hand of man's hubris – for example, holocausts, ethnic cleansing, torture – represent yet another set of circumstances where mortality will have different meaning. In these cases, 'facing death' refers to acceptance after the event for family members more than for the persons dying – although of course some affected people may still face dying after the trauma of natural events or the hand of man where they were significantly harmed but not killed. A different story would need to be developed in these contexts.
- ⁴ For a good yet brief introduction to 'the material turn' in the social sciences, see Islam (2016). Nichterlein (2013) presents this critique in the context of family therapy. Interestingly, a similar critique is done within social constructionism itself by John Shotter (1993), one of its most renowned theorists. Shotter's critique is at the absence of an awareness of class in the politics of everyday life.

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