

## The Melbourne Family Grief Study, II: Psychosocial Morbidity and Grief in Bereaved Families

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***Objective:** The aim of this study was to describe the intensity of grief, the psychosocial morbidity, and the coping patterns in members of families classified according to a typology of family functioning comprising supportive, conflict-resolving, intermediate, sullen, and hostile classes. **Method:** One hundred fifteen families were assessed longitudinally 6 weeks (time 1), 6 months (time 2), and 13 months (time 3) after the death of a parent (constituting 670 individual responses) on measures of grief intensity, psychological state, social adjustment, and family coping. A previously described typology of perceptions of family functioning was applied. Repeated measures multivariate analysis of variance based on both individuals and families and post hoc comparisons of significant results were undertaken. **Results:** Sullen families displayed the most intense grief and the most severe psychosocial morbidity. Well-functioning families (supportive and conflict-resolving) resolved their grief and adjusted more adaptively than their dysfunctional counterparts (intermediate, sullen, and hostile families). There were no cluster-by-time interactions. The clusters accounted for 15.7% of the variance in depression (Beck Depression Inventory) and 27.9% of the variance in social functioning (Social Adjustment Scale). Well-functioning families used more family coping strategies (Family Crisis Oriented Personal Evaluation Scales). **Conclusions:** More intense grief and greater psychosocial morbidity are found in sullen, hostile, and intermediate bereaved families than in the more adaptive supportive and conflict-resolving types. At-risk families are identifiable and could be treated preventively to reduce morbidity.*

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Most research on bereavement has focused on the individual experience (1). There is, however, increasing realization that a person's reactions may be influenced markedly by his or her intimate group, most commonly the family (2-5). The death of one family member affects each other member as well as the family as a whole (6-8). Given that the pattern of family functioning could substantially affect the course of family grief, prospective studies of bereaved families have been proposed (9-11).

In a companion article in this issue of the *Journal*, we describe five patterns of family functioning derived from the dimensions of cohesiveness, conflict, and ex-

pressiveness on the Family Environment Scale (12). Two patterns involved adaptive families: supportive families were distinguished by high cohesiveness, while conflict-resolving families were protected from distress over their differences by their cohesiveness. Two classes were clearly maladaptive: hostile families showed high conflict, poor cohesiveness, and low expressiveness; sullen families had similar but more moderate functional limitations. The fifth class, termed intermediate, exhibited midrange cohesiveness, as well as low control and low achievement orientation (from the Family Environment Scale).

In an effort to determine the clinical utility of this classification, we examined levels of grief, psychological morbidity, and social adjustment as well as styles of coping in families within each of the five classes over the 13 months after the death of a parent.

### METHOD

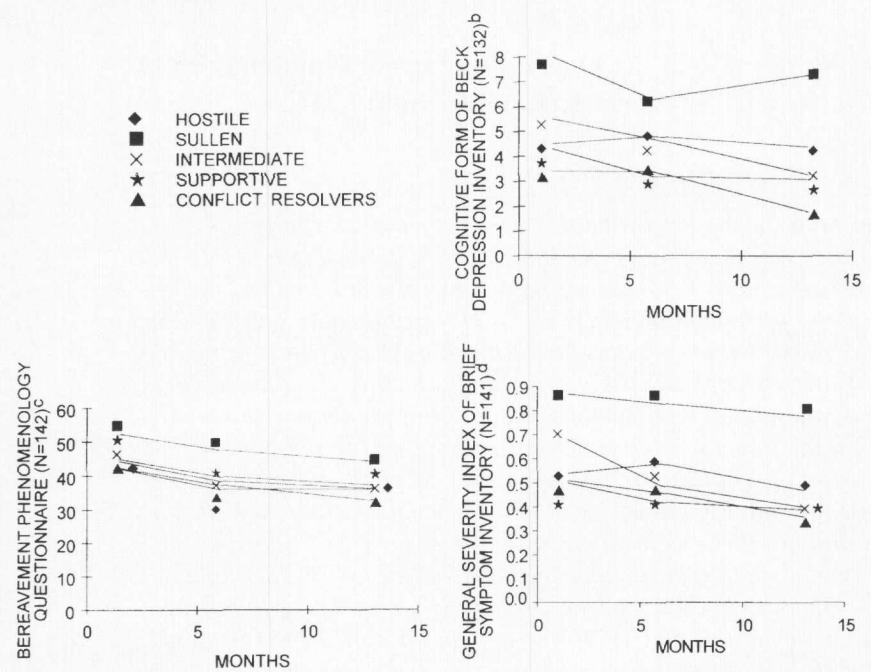
Patients who had died of cancer were identified from the oncology department of a metropolitan general hospital, St. Vincent's in Melbourne, Australia, and its associated hospice, Caritas Christi. Inclusion criteria for the study were death of a patient between the ages of 40

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**FIGURE 1. Psychological Morbidity (Beck Depression Inventory and Brief Symptom Inventory) and Severity of Grief (Bereavement Phenomenology Questionnaire) 6 Weeks, 6 Months, and 13 Months After a Parent's Death in Five Clusters of Families Classified According to Their Type of Functioning at 6 Weeks<sup>a</sup>**



<sup>a</sup>Repeated measures multivariate analysis of variance, with the individual as the unit of analysis, was used in the statistical analysis. There were no significant interactions between time and cluster.

<sup>b</sup>Significant main effect of cluster:  $F=5.91$ ,  $df=4$ , 127,  $p<0.001$ . Significant main effect of time:  $F=7.27$ ,  $df=2$ , 126,  $p<0.01$ .

<sup>c</sup>Significant main effect of cluster:  $F=4.39$ ,  $df=4$ , 137,  $p<0.01$ . Significant main effect of time:  $F=4.39$ ,  $df=2$ , 136,  $p<0.001$ .

<sup>d</sup>Trend-level main effect of cluster:  $F=2.65$ ,  $df=4$ , 136,  $p<0.04$ . Significant main effect of time:  $F=11.41$ ,  $df=2$ , 135,  $p<0.001$ .

and 65 years whose family had an adequate command of English, was geographically accessible, and included a living partner and one or more children aged 12 years or older. This last requirement was necessary so that the children would be able to complete a set of questionnaires.

*Measures and Procedure*

Grief was measured with the Bereavement Phenomenology Questionnaire, a 22-item self-report scale with satisfactory internal consistency (Cronbach's  $\alpha=0.93$ ), reliability, and face and concurrent validity (13, 14). Items covered intrusive and distressing images and thoughts of the deceased person, separation anxiety, nostalgia, and emotional aspects of grief (e.g., sadness, anger, guilt) (14).

Cognitive items of the Beck Depression Inventory and the Brief Symptom Inventory were selected to measure levels of psychological morbidity. The short form of the Beck Depression Inventory correlates satisfactorily with the full version; Scogin et al. (15) recommend a score of 5 or more as the threshold for "caseness." More than 25 years of psychometric evaluation confirms its reliability (internal consistency and stability) and validity (content, concurrent, discriminant, and construct) (16).

The Brief Symptom Inventory (17), a reduced version of the Hopkins Symptom Checklist-90, yields global ratings of psychological morbidity (the general severity index) and scores on nine subscales: somatization, obsessive-compulsive behavior, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The Brief Symptom Inventory has established reli-

ability, with alpha coefficients between 0.68 and 0.91 (18), and has shown both convergent and predictive validity in many studies. Normative data are available to determine threshold scores for operational "caseness" (17).

We used the modified Social Adjustment Scale (19) to assess social functioning in the domains of housework, work, recreation, relationships with children and extended family, and overall social functioning, either with or without a partner. It has proved useful as a measure of change in social adjustment over time and its relation to other psychological and family variables.

Family functioning was assessed with the Family Environment Scale (12) and the Family Adaptability and Cohesion Evaluation Scales (FACES III) (20), both described fully in our companion article in this issue. Family coping strategies were also examined with the Family Crisis Oriented Personal Evaluation Scales (21); its subscales cover use of social support, religion, community resources, reframing (toward a more optimistic view), and passive appraisal (e.g., "believing if you wait long enough the problem will go away"). The internal reliability of this instrument is satisfactory, with alpha coefficients between 0.63 and 0.83; the test-retest reliability is 0.81, and factor analysis supports the construct validity (21).

Relatives of the deceased person were approached, and written informed consent was obtained from each participating family member. The spouse was interviewed initially either in the hospital or in the home after 6 weeks of bereavement (time 1), and then the children were approached through arrangements with the spouse. Follow-up interviews were conducted 6 months (time 2) and 13 months (time 3) after the death. Respondents completed questionnaires independently.

*Statistical Analysis*

Using the class structure of family functioning derived from the cluster analysis (22, 23) described in our companion article, we conducted repeated measures multivariate analysis of variance (MANOVA) (24) to assess the main effects of cluster (a between-subjects factor) and time since the death (a within-subjects or repeated measures factor) and the interaction between them, and to determine the effects of each upon level of grief, psychological morbidity, social adjustment, and patterns of family coping. We conducted these MANOVAs first with individuals and then again with families in a hierarchical model, as described in the companion article. Only complete data sets across the three time points were used; the significance level was set at 0.01. Intraclass correlation coefficients (ICCs) (25), representing the statistical relation between family members within clusters, were also calculated.

In the event of a significant main effect of cluster membership, the KnowledgeSEEKER program (26) was applied for post hoc analyses, as described in the companion article, merging clusters whose means on the dependent variable were not significantly different from each other (at the  $p=0.05$  level), with the final result adjusted for the number of comparisons performed. In contrast with alternative techniques (27), KnowledgeSEEKER is easier to interpret than simple pairwise comparisons of means; it has been theoretically validated on simulated data (28) and previously applied to psychiatric data (29-31). When categorical analyses were applied, the chi-square statistic was used (24).

**TABLE 1. Grief and Depression in Five Types (Clusters) of Bereaved Families 6 Weeks After a Parent's Death<sup>a</sup>**

Measure	Score for Total 6-Week Data Set		Analysis of Variance		Post Hoc Analysis of Clusters				
	Mean	SD	F	df	Grouping of Family Types	N	%	Mean	SD
Bereavement Phenomenology Questionnaire (grief) (N=250)	43.81	11.87	8.57*	1, 248	Sullen and supportive	118	47	46.10	12.13
					Conflict-resolving, intermediate, and hostile	132	53	41.77	11.29
Beck Depression Inventory (cognitive form) (N=243)	5.02	4.84	10.76**	2, 240	Sullen and hostile	71	29	7.01	5.78
					Supportive and intermediate	115	47	4.65	4.58
					Conflict-resolving	57	23	3.30	2.92

<sup>a</sup>The individual was the unit of analysis. The KnowledgeSEEKER program (26) was used for the post hoc analyses.

\*p=0.06. \*\*p<0.001.

**RESULTS**

Of the 169 families approached, 115 (68%) were recruited for the study. The total of 670 individual responses forming the data set was obtained from 115 spouses and 153 offspring. Reasons for nonresponse and dropout are described in the companion article.

The mean age of the 115 spouses, 53% of whom were female, was 55.9 years (SD=9.2), and the mean age of the 153 offspring, 52% of whom were female, was 28.2 years (SD=7.7). Families had a mean of 3.1 children (SD=1.6).

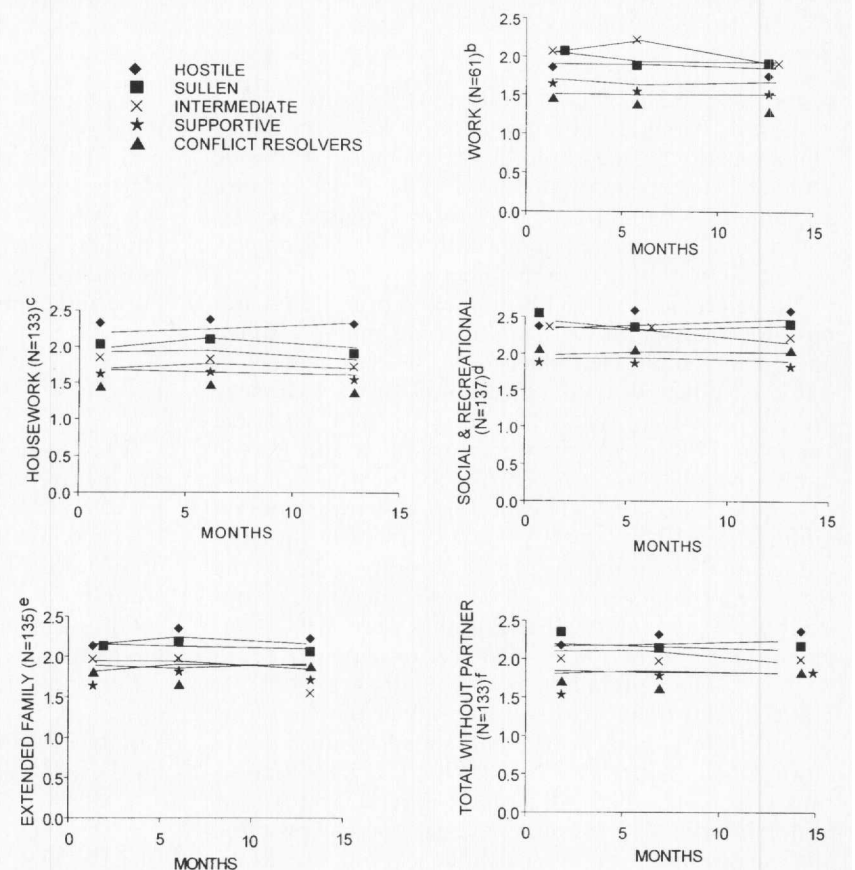
Spouses identified their family's ethnic background as follows: Australian, 66%; English, 11%; Eastern European, 7%; Italian, 5%; Irish, 4%; Asian, 2%; Greek, 1%; and other, 4%. Religious affiliation was cited as Christian by 85% (Catholic, 32%; Protestant, 53%), Jewish by 3.5%, and none by 8%.

The cause of the death was lung cancer in 20% of the families, breast cancer in 20%, bowel cancer in 17%, brain cancer in 7%, lymphoma in 4%, prostate cancer in 4%, melanoma in 3%, leukemia in 3%, kidney cancer in 3%, and other in 19%. The mean duration of illness was 34.3 months (SD=40.8).

*Analyses of Psychosocial Functioning Based on Individuals*

The class structure derived from time 1 was applied to all data, and repeated measures analysis of variance (ANOVA) was calculated for the clusters across time on scores on the Bereavement Phenomenology Question-

**FIGURE 2. Social Functioning (Social Adjustment Scale) 6 Weeks, 6 Months, and 13 Months After a Parent's Death in Five Clusters of Families Classified According to Their Type of Functioning at 6 Weeks<sup>a</sup>**



<sup>a</sup>Repeated measures multivariate analysis of variance, with the individual as the unit of analysis, was used in the statistical analysis. Time was not significant for any subscale. There were no significant interactions between time and cluster.

<sup>b</sup>Significant main effect of cluster: F=3.99, df=4, 56, p<0.01.

<sup>c</sup>Significant main effect of cluster: F=4.11, df=4, 128, p<0.01.

<sup>d</sup>Significant main effect of cluster: F=7.41, df=4, 132, p<0.001.

<sup>e</sup>Significant main effect of cluster: F=4.38, df=4, 130, p<0.01.

<sup>f</sup>Significant main effect of cluster: F=7.59, df=4, 128, p<0.001.

naire, Beck Depression Inventory, and general severity index (Brief Symptom Inventory) (figure 1). Time ac-

TABLE 2. Social Adjustment in Five Types (Clusters) of Bereaved Families 6 Weeks After a Parent's Death<sup>a</sup>

Measure on Social Adjustment Scale	Score for Total 6-Week Data Set		Analysis of Variance		Post Hoc Analysis of Clusters				
	Mean	SD	F	df	Grouping of Family Types		N	%	Mean
Total social adjustment (N=243)	2.03	0.41	35.63***	1, 241	Supportive and conflict-resolving	128	53	1.89	0.38
					Intermediate, sullen, and hostile	115	47	2.19	0.39
Total social adjustment when partner was living (N=119)	2.18	0.39	12.63*	1, 117	Supportive, conflict-resolving, and intermediate	85	71	2.10	0.39
					Sullen and hostile	34	29	2.37	0.33
Social and recreational functioning (N=248)	2.19	0.54	46.46***	1, 246	Supportive and conflict-resolving	131	53	1.99	0.46
					Sullen, intermediate, and hostile	117	47	2.42	0.54
Housework (N=244)	1.88	0.61	12.39*	1, 242	Supportive and conflict-resolving	128	52	1.75	0.54
					Sullen, intermediate, and hostile	116	48	2.02	0.65
Relationship with extended family (N=245)	2.04	0.45	22.47**	1, 243	Supportive, conflict-resolving, and intermediate	172	70	1.96	0.42
					Sullen and hostile	73	30	2.24	0.44

<sup>a</sup>The individual was the unit of analysis. The KnowledgeSEEKER program (26) was used for the post hoc analyses.

\* $p < 0.05$ . \*\* $p < 0.001$ . \*\*\* $p < 0.0001$ .

counted for 39.2% of the variance and the clusters 11.4% in the grief variable on the Bereavement Phenomenology Questionnaire, as measured by the eta-squared statistic (26). The clusters accounted for 15.7% of the variance and time 10.3% in the Beck Depression Inventory scores. Sullen families registered significantly more grief and psychological morbidity than the other family clusters.

With KnowledgeSEEKER applied to time 1 data as a post hoc analysis for these multivariate analyses, sullen and hostile families had the greatest level of depression (table 1). When we used a threshold score of 5 or more on the Beck Depression Inventory in the categorical analysis, 54% of the members of sullen and hostile families were "cases" in contrast to 26% of members of supportive, conflict-resolving, and intermediate families ( $\chi^2=17.55$ ,  $df=1$ ,  $p<0.01$ ). Similarly, in categorical analyses using the general severity index of the Brief Symptom Inventory, 24% of the members of sullen, hostile, and intermediate families were cases, compared with a mere 7% of members of supportive and conflict-resolving families ( $\chi^2=13.36$ ,  $df=1$ ,  $p<0.01$ ).

Social adjustment was consistent over time in terms of the clusters, with hostile and sullen families doing more poorly (figure 2). Time did not exert any significant effect on social adjustment (Social Adjustment Scale). Intermediate families were grouped by post hoc analyses at time 1 (table 2) with the less functional sullen and hostile families on housework, work, social and recreational functioning, and overall social functioning. The clusters accounted for between 19.2% and 27.9% of the variance in total functioning (without partner versus with partner) on the Social Adjustment Scale.

Time exerted significant effects on family coping (Family Crisis Oriented Personal Evaluation Scales) (figure 3); families made less use of religion, social support, community resources, and reframing optimistically while increasing passive appraisal. Cluster tended to affect overall coping, use of social support, and re-

framing; post hoc comparison confirmed hostile families' lower use of social supports ( $F=15.88$ ,  $df=1$ , 246,  $p<0.01$ ). Adaptive families (supportive and conflict-resolving) generally made greater use of coping strategies than very dysfunctional families (hostile), but sullen families, noted for the highest levels of psychological morbidity, made the most use of religion, social support, and community resources.

#### *Analyses of Psychosocial Functioning Based on Families*

When we used the family as the unit of analysis in the hierarchical model, a significant effect of cluster persisted for the Beck Depression Inventory, where the ICC was low, but was lost for the Bereavement Phenomenology Questionnaire, where the ICC was moderate (table 3).

For social adjustment (table 4), the ICC was only moderate for the subscale concerning relationship with the extended family; all other subscales maintained significance. However, high ICCs were evident for the Family Crisis Oriented Personal Evaluation Scales (table 5), and clusters were not significant.

#### DISCUSSION

The families in the study were typical of those of adult patients with cancer who attend oncology departments of general hospitals, that is, families challenged to cope with the prospect and eventual reality of a death from cancer and the associated bereavement. They included parents who were middle-aged or in early old age with teenage and young adult children living in or outside the grieving spouse's home. The study group, however, was biased because of the nonresponders, the dropouts, and the study's requirement for spoken English, although one-third were of migrant status. It is possible that there was

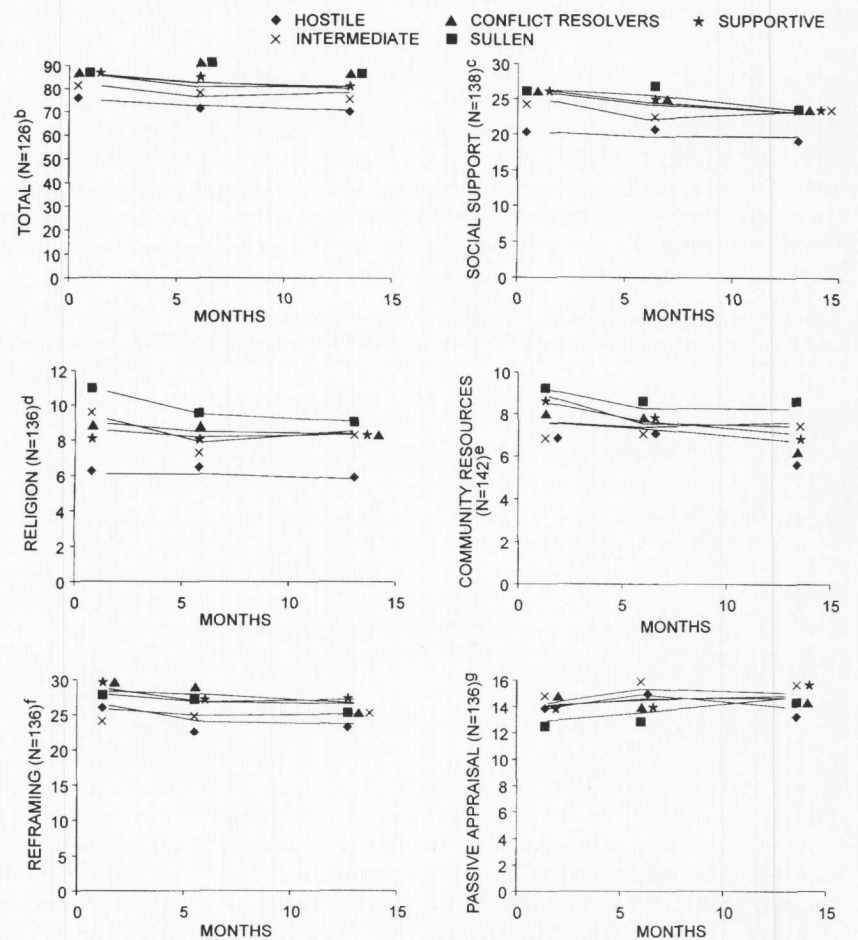
further bias because of the exclusion of patients older than 65 years; we believe that separate studies are required, focusing on other phases of the family life cycle, including the death of children, young adults, and the elderly (32).

Our classification of families based on dimensions of their functioning (cohesiveness, conflict, expressiveness) is discussed in our companion article. In this report we see its clinical usefulness in identifying families at risk of psychosocial morbidity. Sullen families not only experienced the most intense grief but also were at greatest risk of depression. The two maladaptive families grouped by post hoc analyses, hostile and sullen, showed significantly greater depression and overall psychological distress. Intermediate families merged with this dysfunctional pair in displaying reduced overall social adjustment as well as decreases in the domains of housework and social and recreational functioning. In contrast, supportive and conflict-resolving families showed low psychosocial morbidity on all variables measured.

It is noteworthy that the intensity of grief in supportive families was second only to that of sullen families and was grouped with the latter in post hoc analyses at time 1. The supportive family members expressed their sense of loss freely but without adverse psychosocial sequelae, ostensibly because the family cohesiveness facilitates sharing of distress while at the same time enabling mutual consolation and caring.

Conflict-resolving families, the other class of adaptive families, also showed minimal psychosocial morbidity but expressed less intense grief

**FIGURE 3. Family Coping Styles (Family Crisis Oriented Personal Evaluation Scales) 6 Weeks, 6 Months, and 13 Months After a Parent's Death in Five Clusters of Families Classified According to Their Type of Functioning at 6 Weeks<sup>a</sup>**



<sup>a</sup>Repeated measures multivariate analysis of variance, with the individual as the unit of analysis, was used in the statistical analysis. There were no significant interactions between time and cluster.  
<sup>b</sup>Trend-level main effect of cluster:  $F=2.84, df=4, 121, p<0.03$ . Significant main effect of time:  $F=13.37, df=2, 120, p=0.001$ .  
<sup>c</sup>Trend-level main effect of cluster:  $F=2.70, df=4, 133, p<0.04$ . Significant main effect of time:  $F=9.76, df=2, 132, p<0.001$ .  
<sup>d</sup>Significant main effect of time:  $F=5.83, df=2, 130, p<0.01$ .  
<sup>e</sup>Significant main effect of time:  $F=7.15, df=2, 136, p<0.01$ .  
<sup>f</sup>Trend-level main effect of cluster:  $F=2.63, df=4, 131, p<0.04$ . Significant main effect of time:  $F=8.59, df=2, 130, p<0.001$ .  
<sup>g</sup>Significant main effect of time:  $F=9.13, df=2, 131, p<0.001$ .

**TABLE 3. Repeated Measures Multivariate Analysis of Variance for Depression, Grief, and Global Distress 6 Weeks, 6 Months, and 13 Months After a Parent's Death in Five Clusters of Bereaved Families Classified According to Their Type of Functioning at 6 Weeks<sup>a</sup>**

Measure	Effect of Cluster		Effect of Families Within Cluster		Intraclass Correlation Coefficient	Effect of Time	
	F	df	F	df		F	df
Beck Depression Inventory (cognitive form) (N=82)	4.30***	4, 61	n.s.		0.05	13.68†	2, 16
Bereavement Phenomenology Questionnaire (grief) (N=92)	n.s.		1.78*	68, 19	0.38	32.94†	2, 18
Brief Symptom Inventory (general severity index) (N=94)	n.s.		n.s.		0.16	3.68**	2, 19

<sup>a</sup>A hierarchical model, with the family as the unit of analysis, was used. Family types were supportive, conflict-resolving, intermediate, sullen, and hostile. There were no interactions between time and cluster or between time and families within cluster.  
 \* $p=0.08$ . \*\* $p=0.04$ . \*\*\* $p<0.01$ . † $p<0.001$ .

**TABLE 4. Repeated Measures Multivariate Analysis of Variance for Social Adjustment 6 Weeks, 6 Months, and 13 Months After a Parent's Death in Five Clusters of Bereaved Families Classified According to Their Type of Functioning at 6 Weeks<sup>a</sup>**

Subscale of Social Adjustment Scale	Effect of Cluster		Effect of Families Within Cluster	Intraclass Correlation Coefficient	Effect of Time
	F	df			
Work (N=47)	3.93**	4, 34	n.s.	0.00	n.s.
Housework (N=87)	3.60**	4, 66	n.s.	0.06	n.s.
Social and recreational functioning (N=89)	5.61***	4, 66	n.s.	0.03	n.s.
Relationship with extended family (N=87)	3.11*	4, 64	n.s.	0.28	n.s.
Total social adjustment without partner (N=88)	6.68***	4, 65	n.s.	0.00	n.s.

<sup>a</sup>A hierarchical model, with the family as the unit of analysis, was used. Family types were supportive, conflict-resolving, intermediate, sullen, and hostile. There were no interactions between time and cluster or between time and families within cluster.

\*p<0.05. \*\*p<0.01. \*\*\*p<0.001.

**TABLE 5. Repeated Measures Multivariate Analysis of Variance for Family Coping Styles 6 Weeks, 6 Months, and 13 Months After a Parent's Death in Five Clusters of Bereaved Families Classified According to Their Type of Functioning at 6 Weeks<sup>a</sup>**

Subscale of Family Crisis Oriented Personal Evaluation Scales	Effect of Cluster		Effect of Families Within Cluster		Intraclass Correlation Coefficient	Effect of Time	
	F	df	F	df		F	df
Social support (N=91)	n.s.	2.04***	69, 17	0.46	9.44†	2, 16	
Religion (N=89)	n.s.	4.98††	68, 16	0.77	4.66***	2, 15	
Community resources (N=95)	n.s.	n.s.	n.s.	0.29	4.27***	2, 18	
Optimistic reframing (N=93)	2.08*	4, 70	n.s.	n.s.	0.00	3.14**	2, 17
Passive appraisal (N=93)	n.s.	n.s.	3.02†	71, 17	0.62	7.88†	2, 16

<sup>a</sup>A hierarchical model, with the family as the unit of analysis, was used. Family types were supportive, conflict-resolving, intermediate, sullen, and hostile. There were no interactions between time and cluster or between time and families within cluster.

\*p=0.09. \*\*p<0.07. \*\*\*p<0.05. †p<0.01. ††p<0.001.

than supportive families. A striking feature was the change in hostility (Brief Symptom Inventory) in these families, which was reduced by one-half over the 13 months and reached levels found in the supportive and intermediate families, in marked contrast to their maladaptive counterparts. Moreover, conflict-resolving families had the lowest levels of depression, perhaps an inherent feature of their adaptiveness.

While our classification of families generated significant effects of cluster on grief (Bereavement Phenomenology Questionnaire) and depression (Beck Depression Inventory) in analyses based on the individual, this effect was lost for grief when the family was used as the unit of analysis. A higher ICC was evident, indicating that grief was a more shared phenomenon than depression. However, in the statistical application of the hierarchical model, only perceptions of family members nested in the same cluster were entered into the analysis, outliers being omitted. It will not be surprising to clinicians to see that the richness of understanding of the family is weakened when we delete the viewpoints of some of its members, particularly those whose perspective is not in agreement with that of the majority. There remains considerable methodological difficulty in analyzing families, and our work provides a challenge for the development of further statistical techniques that deal with ICCs without the necessity of sacrificing data that appear to be clinically relevant.

Social adjustment did not change significantly over the 13 months. This stability is comprehensible, given

that our study group was drawn from the community rather than a psychiatric population; deterioration in areas such as work, housework, and social and recreational functioning would be expected only in individuals with substantial psychological impairment. However, our typology of family functioning exerted a major effect on social adjustment, accounting for up to a substantial 28% of the variance in overall adjustment, and this effect persisted in the hierarchical analyses. This supports the typology's discriminative value.

Our use of a family coping measure shed additional light on the process of family grief. Significant change over time in deployment of these coping strategies corresponded with grief resolution, particularly less need for social and spiritual support and reduced reliance on community resources. Diminished optimistic reframing was linked with a rise in passive appraisal. Furthermore, hostile families were strikingly different from the four other groups in using fewer adaptive coping strategies. Their disruptive style of relating—poor communication and high conflict—was matched by their inability to avail themselves of social support, use community resources, and seek spiritual support. On these dimensions they contrast with sullen families, who, as if in appreciation of their distress, do seek support, both spiritual and social, and make use of community resources. Hence, use of these strategies distinguishes between the two most dysfunctional classes; hostile families appear impervious to help, whereas sullen families search for the assistance they sense they need. This dis-



inction may be relevant when we consider therapeutic interventions with these families.

Our findings on the association between family functioning and outcome of grief are supported by clinical observation. Munson (33), for example, highlighted family conflict as a factor in the nonresolution of grief, and Vollman et al. (34) differentiated between cohesive families with supportive social networks and families that were closed and socially isolated in their experience of grief. Similar differences between adaptive and maladaptive patterns have been described in younger families after the death of a child (35). One-third of these families inhibited discussion, suppressed feelings of grief, avoided change, and rejected support, features resembling those of our maladaptive families.

Given the close link between family functioning and the psychosocial outcome of bereavement, there is value in clinicians assessing the family routinely in order to identify and assist those at risk of complicated grief. Clinicians, especially general practitioners, would do well to develop skills in recognizing dysfunctional families, primarily by appraising their levels of cohesion, conflict, and expression of thoughts and feelings. The 12 items comprising the short version of the family relationship index could assist them in this task, enabling categorization of families according to our typology.

In a pioneering study, Paul and Grosser (2) described their therapeutic approach of "operational mourning," in which families are encouraged to reflect on their loss, share associated feelings, and understand the impact of the death on themselves. Since that study, only a few such family intervention studies have been done. Moreover, findings have been strikingly inconsistent, even contradictory (36). Whereas Lieberman (37) and Rosenthal (38), for instance, found improvement with their therapy for complicated mourning, this was not achieved preventively by Williams and Polak (39) and by Black and Urbanowicz (40). In fact, Williams and Polak cautioned about the intrusiveness of premature intervention. We surmise that failure to select at-risk families may have been a crucial reason that these last two studies failed to demonstrate positive change. When families are grieving adaptively, we ought to respect their potential to complete the task effectively. On the other hand, when families are at risk, because their functioning is hostile, sullen, or intermediate, preventive intervention seems warranted. Controlled treatment studies of at-risk families are needed to elucidate the efficacy of this initiative. It should seek to promote mutual understanding and support, enhance the capacity to resolve conflict, and develop open expression of thoughts and feelings. Supportive and engaging messages by the clinician (for example, acknowledging sadness, complimenting openness, reassuring that change will ensue, and confirming the value of working together) have been successfully used in family therapy where morbid grief predominated (41) and could be readily deployed for at-risk families.

## CONCLUSIONS

Grief, an experience confronting all of us as individuals and, of necessity, our families, is a process of adjustment in which the growth of everyone involved can be facilitated. On the other hand, failure to grieve in an adaptive manner potentially paves the way for substantial morbidity. Understanding how families grieve is a cornerstone for enabling them to do so effectively. Recognition of the type of family functioning, whether supportive or conflict-resolving, as in adaptive families, or hostile, sullen, or intermediate, as in more dysfunctional families, provides a basis for coherent intervention. Evaluation of cohesion, conflict, and expressiveness permits such a classification and, in turn, identification and prompt treatment of at-risk families.

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