OMEGA THERAPY:
COUNSELING THE DYING & THEIR FAMILIES

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Arts in
Educational Psychology
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"Light and Darkness? I do not think you can have one without the other. Death is part of life and there is something that gives life its quality - and helps it to new beginnings."

Cicely Saunders
Acknowledgements:

To Virginia Satir, for her care and her time and to Janet Reynolds-Howell for her interest and energy.
Dedication:

With love and deep appreciation to all my family and special friends who have added rich and lasting themes and images to mine with which to work my life.
ABSTRACT

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by
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The psychosocial care of the dying and their families may be effected by exploring a definite therapeutic approach. This thesis attempts to present and describe such an approach - Omega Therapy.

The literature reviewed indicated the needs of the dying and the necessity of responding to those needs; the Hospice concept; the absence of a particular therapeutic approach specifically intended for the special needs of the dying and that the dying person and the family are to be considered as one unit.

The development of a specific approach to counseling the dying and their families was seen to have been forecasted in the work and ideas of Gordon (1978), Kantor and Lehr (1978) and Shniedman (1978).
The purpose of Omega Therapy is to provide a therapeutic tool for diagnosis and treatment of the dying and their families and to enable growth and transformation experiences to occur in the dying process.

The desired outcome of Omega Therapy is (a) to assist the dying-transforming family to successfully conclude their life's business, (b) to accept loss with appropriate goodbye taking, and (c) to further support the survivors in the bereavement process.

The central components of Omega Therapy are the therapeutic concepts and uses of Jungian archetypal themes and images and Saterian family communication patterns and roles.

The central dynamics of Omega Therapy are the use of non-interpretive dialogue in the framework of the dying-transforming family's given archetypal language and communication patterns and the development of a relationship to the dying process through an altered use of active imagination and psychodrama methods.

To illustrate the therapeutic viability and usefulness of Omega Therapy, sessions from five case studies were selected, presented and evaluated with respect to archetypal themes and images along with family communication patterns and roles. The archetypal representations and communication patterns which emerged were separated into the two major polarities of alienation and liberation for
the purpose of showing the contrasting family psychological statuses in the dying-transforming process.

Recurring archetypal themes and images of alienation include Separation, Drowning, Devouring or Terrible Mother, Victim, Scapegoat and the Clock. Recurring family communication patterns and roles include anger, denial, grief, helplessness, Placator, Blamer and Distracter. Some recurring archetypal themes and images of liberation includes Union and Fusion, Initiation, Visitation from the deceased and the Dance.

Examples of the successful application of Omega Therapy may be said to be found in the evolution of the "E" and "W" families. Their initial, alienated position to the transformed, liberated orientation was reflected in the changed cycles of their archetypal themes and images and communication patterns.

Questions for further research include (a) the therapists own archetypal themes in relationship to the dying process, (b) the effects of archetypal influences in staff relationships and stress in working with the dying and (c) the effective use of archetypal material in general family therapy.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER II</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER III</td>
<td>28</td>
</tr>
<tr>
<td>CHAPTER IV</td>
<td>68</td>
</tr>
<tr>
<td>CHAPTER V</td>
<td>151</td>
</tr>
<tr>
<td>REFERENCES</td>
<td></td>
</tr>
<tr>
<td>APPENDICES</td>
<td></td>
</tr>
</tbody>
</table>
INTRODUCTION

Importance and Need for the Study

This area of study is important because there is no clear, systematic approach to a psychosocial therapy with the dying and their families nor is there therapeutic concept that can apply to the family dynamics in the dying process. The combined use of family therapy and archetypal themes and images in a therapeutic approach with the dying and their families is suggested so that there may be a theoretical basis to continue the psychosocial care of the dying. The concepts of such psychosocial care are in their pioneering stages and are broad enough to incorporate the communication developments of family therapy and the psychotherapeutic use of symbol and imagery.

One of the crucial issues that address a therapy with the dying and their families is that such psychosocial care is supportive and appropriate to the elements of growth and healing in family systems and is not an attempt at change or "cure" of the persons or situation.

Statement of the Problem

Dying and death may create crisis, trauma and severe disruption in the dying individual, family members and in family patterns. Family members, as well as the dying individual, need support and guidance throughout the dying
process so that they can maximize the quality of their lives together and to recognize death as a more natural transformative process than a pathological occurrence.

**The Purpose of the Study**

The purpose of the study is to develop an approach to meet the psychosocial needs of the individual and their families which are unique to the dying process.

**The Justification of the Approach**

The integration of family dynamics and archetypal images and themes (Satir and Jung) is both a reasonable and justifiable rationale for the psychosocial care of the dying and their families because the integrated approach applies both the principles of family groups and psychodynamics to the dying process. Such an integrated approach provides a lens by which to focus on intra psychic dynamics of family life and how they affect the dying individual and potential survivors in the family. Such a focus also provides a platform to understand and ameliorate the grief and bereavement process that follows a death of a significant family member.

**The Format of the Study**

The study consists of an:

a) Introduction which states (1) the importance and need
for the study (2) the statement of the problem (3) the purpose of the study (4) and the justification of the approach.

b) Background and review of the literature which contains (a) a brief history of the death and dying field (b) an overview of the area of death and dying; (c) a discussion of the therapeutic approaches to death and dying with an introduction to the Hospice movement... special emphasis is placed on the existing ambivalence in therapeutic theory and practice; (d) description of family dynamics and treatment strategies and the use of images in the therapeutic family process; (e) a presentation of family therapy approaches of Virginia Satir applied to therapy in the dying process; (f) a presentation of the archetypal theories of Carl Jung applied to therapy in the dying process; and (g) an introduction to a suggested therapeutic approach for death and dying which integrates aspects of the work of Satir and Jung in addressing the psychosocial dynamics of the process as well as some therapeutic and psychosocial problems unique to this process.

c) Chapter III presents the description and needs of the dying transforming family, and the therapeutic approach.

d) Chapter IV presents the description of its application in selected case studies.

e) Chapter V is a summary of the study providing sugges-
tions for further research.
CHAPTER II

Background and Review of the Literature

The background and review of the literature includes (a) a brief history of the death and dying field; (b) an overview of the area of death and dying; (c) a discussion of some current therapeutic approaches to death and dying with a brief introduction to the Hospice movement... special emphasis is placed on the existing ambivalence in therapeutic theory and practice; (d) a description of family dynamics, treatment strategies and the use of images in the therapeutic family process; (e) a presentation of family therapy approaches of Virginia Satir applied to therapy in the dying process; (f) a presentation of the archetypal theories of Carl Jung applied to therapy in the dying process; and (g) an introduction to the purpose for a suggested therapeutic approach to death and dying which integrates aspects of the work of Satir and Jung in addressing the psychosocial dynamics of the dying process as well as some therapeutic and psychological problems unique to this process.

In the last decade, much attention has been given to the issues involved in death and dying.

In 1955, Eissler wrote The Physician and the Dying Patient and again in 1956, Gorer's article "Death as the Last Taboo" brought attention to the problems of the dying
in our society.

It was not until the mid-sixties that definite and particular attention began with the pioneering investigations of Drs. Cicley Saunders, in England, and Elizabeth Kubler-Ross in Chicago, emerging from their writings and research came descriptions of the plight of the terminally ill and their families. With those findings, they presented suggestions of what to do to help ameliorate the alienation and isolation of the dying both in terms of medical, psychosocial and spiritual dimensions. For the most part, subsequent literature on the care of the terminally ill has come from the medical sciences, with emphasis on nursing and pharmacological care of the dying person. This is not to ignore, however, the concern expressed in many articles, books and workshops now devoted to the psychosocial needs of the dying.

An Overview of the Death and Dying Field

An overview of the death and dying field today contrasts greatly with an overview of six years ago. In 1974, the subject of death and dying was indexed under medical, literary and religious works, with very little references to psychosocial needs except with reference to dying child themes. Gorer (1956) wrote the first popular work of its kind on death that made inroads into the public consciousness. In this work he called death "The Last Taboo."
Along with the recent growing awareness of death and dying come issues that are new and foreign to dying as it was previously understood. Industrial and technological domination of social life have forced certain issues upon us which need to be taken into account, if we are to look at how to deal with individuals and families undergoing the dying process. Among those issues are: (a) approximate medical timing of treatment of the terminally ill; (b) informed consent for policies for patient and/or family; (c) decisions about the use of "heroic measures; (d) living wills; (e) the use of narcotics in pain management; (f) the "right to die" controversy and (g) when, if at all, to tell the individual he/she is dying. All these issues raise questions on the proper treatment of the dying, as well as dust clouds of debate over moral and ethical practices and in legal and political activities. For example one question raised with respect to proper terminal care has concerned psychosocial treatment of the dying person. Dobihal, Jr.,(1974), in an article titled "Talk on Terminal Care" presents an alternative to traditional medical care models and pinpointed the terminal care issue for the medical profession in America by urging them to consider a systematized alternative approach to care for the dying in the form of the Hospice concept: A holistic medical and psychosocial care of the terminally ill and their families. The emphasis is on health care delivery once again, but
touches repeatedly on the concept of patient and family without emphasis on the psychosocial needs of that unity. The political and ethical debates which surround effective treatment of the dying person create an ambivalence within the field of death and dying about what to do for the psychosocial needs of the patient and family. Literature describing the needs and the crucial need to attend to such needs of the dying person is plentiful; some are (Feifle, 1959; Garfield, 1978; Hendin, 1973; Koestenbaum, 1974; Kutscher, 1973; Parkes, 1972; Kubler-Ross, 1969; Schultz, 1978; Shniedman, 1978; Weisman, 1970.) Yet among those same authors exists a denial or reluctance to apply a therapeutic approach to the dying process. (Kubler-Ross 1969; Koestenbaum 1974). To further illustrate the ambivalence existing in this area Kubler-Ross states that she felt it was useless to do therapy with the terminally ill. Even within the work of one person ambivalent attitudes are to be found (Koestenbaum, 1974) argued that the dying can be helped and supported by means of an elaborate test for psychological and existential pain. However, he also stated that "techniques to help the dying are meaningless because death is a philosophical problem rather than a medical one. Consider that there is no cure for death!" Ambivalent attitudes exist even within the Hospice concept of care for the terminally ill itself. Lamerton, (1977) lectured that it was ridiculous to do
therapy or counseling with the terminally ill, that the only good care is symptom management and "the devil with hand holding psychologists."

The existing ambivalence is understandable. There is no cure for death, and there is a need for the individuals who undergo the dying crisis to have help. The special nature of the death event along with the psychological dynamics it engenders seem to intimidate the development of specific therapeutic approaches or systems to deal with the dying process. It could be speculated that such resistance to developing appropriate therapeutic approaches is related to practitioner's personal sensitivity to and reluctance toward facing their own mortality. Allport, (1965) indicated "...psychology, no less than art, philosophy and religion has important things to say about (death) 'the fatal asterisk'".

Current Therapeutic Approaches

For the purpose of this study the definition used to characterize the term therapy is that which establishes a relationship to the dying process, explores and supports the intra-psychic dynamics of the dying person and the significant others and opens channels of communication between all concerned. Therapy with the dying is of necessity family therapy for the structure and process of family life is radically affected.
Therapy with the dying is also psychotherapy, for individual members have within them dynamic processes that are in exchange with and affect the outer, social world.

Colleagues in the field, some of whom are "thanatologists," social workers, psychologists and counselors relate that they use a variety of established therapeutic and counseling methods and techniques with the terminally ill. One colleague reports that the therapeutic approach in her work is specifically non-specific. Such a position in therapy with the dying seems illustrative of the general attitudes in the death and dying field. Generally caregivers use what is at hand in therapeutic practices in the work with the dying: behavior therapy, reflective listening, psychotherapy, gestalt, dynamic direction of family process, and techniques of crises intervention.

There has not developed a specific, systematic approach for the therapeutic support of the dying process and work with the terminally ill and their families. It is this researchers opinion that there appears to be a need to develop a specifically appropriate approach not only for the benefit of the patient and family but for the therapist as well.

Recent attention to therapy has only begun to touch on the problem of what are counselors doing with the dying,
and to look at the need to focus on the problems and to formulate understandings that are peculiar to the terminal process (Garfield, 1978; Shniedman, 1978). Mount, (1979) agreed with this researchers concern that among the care givers to the dying there exists a lack of awareness of the personal toll exacted by virtue of working with the dying process and he views it as causally possible that while care givers may express awareness of the hazards to personal energy this behavior often contradicts stated awareness. It could be that such a lack of awareness in care givers is also communicated to the patient and minimizes the support available to the dying person and family. Such unintended minimization of support to the people involved can result in increasing isolation and lonliness; fears can become magnified, communication blocked and relationships may disintegrate. The opposite result of what was intended as total care of the dying occurs.

With the nature of the work an important variable in understanding therapy with the dying we must look at what therapy means in this situation. The most common understanding is derived from the medical model; therapy is a practice for cure. It is based on pathology, on something wrong or sick that needs to be made right, turned around. Counseling on the other hand connotes guuidance or adjust­ment and also a sense of correction. Yet there is no
inherent pathology to dying, as it is an inevitable part of life's process. Even when counseling is done there can be no actual correction of the situation. Death is imminent and inevitable. Dying has its own dynamics (Jung, 1935) for both the one who dies and the family members.

Any understanding of therapy with the dying has to take into account (Kubler-Ross, 1969) both the attributed moods of the dying process and (Erikson, 1950) developmental stages that the dying individual might find himself or herself in. The families usual methods of coping no longer work. The therapist needs to understand that entering into a system in time of possible crisis magnifies the importance of the intervening role in the preexisting system and in the highly emotional situation. As such an intervener, the therapist must have a firm ground in order to perceive and cope with the family dynamics and processes, individual processes and interactions and the influence of the death process itself.

The Hospice Approach to Death

The attention to the psychosocial needs form of the dying and their families have been most closely operationalized in the Hospice concept. Hospice is a multi-disciplinarian approach for the holistic care of the terminally ill and their families. The Hospice concept's main goals are to keep the family together in the time of
dying, to relieve ameliorate and sometimes rechannel pain and symptoms of physical and psychosocial stress and to make dying, and therefore living, more humane and meaningful. As codified by (Saunders, 1969), there are four areas of pain for which dying persons require attention. They are (a) physical (2) psychological (c) social and (d) spiritual. All of these areas of pain must be attended to for a "good death." Ideally, Hospice's goals are for people to die at home, surrounded by loved ones, and by doing so to have an effect on refocusing the death event as something to be normally incorporated into the mainstream understanding of human life.

Those goals, if taken literally, would result in a heightened awareness of life and death and demythologize our present myth of scientific coolness and control. Freud and Jung shared the view that no one believes in his own death and that buried in us is a fear that we are not immortal after all. Such a thing as Hospice and therapy with the dying highlights that problem. In therapy with the dying in the face of death, "the goal is now." (Hillman, 1978), as it is with family therapies and change (Bandler, Grindler, Satir, 1975).

Family Dynamics

It is said that people should "die with dignity." That was the popular slogan in the early 1970's as the awareness
of death and dying movement grew. Today caregivers have begun to realize that people die as they live. The patterns of individual and collective life are not only maintained but affirmed and often heightened in the dying process. Also, family patterns and conflicts do not change when the dying process of a significant member occurs. Those patterns and conflicts that have previously existed have done so in a repetitive or circular manner with the attending roles and scripts ascribed to them out of their shared interactions and unconscious life and remain the same. However, in the time of greatest stress those patterns and conflicts are heightened when death threatens the ritual of their collective life. Bossard, (1950) says that ritual in family life is a ritual of prescribed formal behavior to some specific event, occasion or situation which tends to be repeated over and over again. He states that the effects of ritual between people insure a sense of continuity, predictability of behavior, and the glamorization and deepening of relationships. Ritual in the family is also generalization and cyclic and as Eissler, (1955) says, has to do with a family's sense and management of time. In the event of death, the family system is threatened and disrupted and death may be defined as a crisis by the family. Integration of death into the family is not part of the family "map". Satir, (1964) says that the process of "mapping" is what a family does to gain an
image of the pattern of their roles, interactions and strategies. Hill, (1949) says the extra family stress throughout the process of dying alters the status, concepts of roles and membership of the family and can become elements in "family disintegration." Ackerman, (1958) says that:

"The weave of family relations may be affected in a wide variety of ways by either a friendly supportive social environment or a hostile and dangerous one. A social environment which imposes danger may cause a family to go asunder; the unity of the family may crumble as it is invaded by external force." (Page 18).

It is this researcher's observation that families perceive a life threatening illness as an "invader", an outside threat or something foreign to them. This researcher suggests the term "the dying-transforming family" as a term for the unity of the families' expectations and interaction patterns that are no longer able to hold together because of the actual loss of a significant member. The term "dying-transforming" takes into account both the dying individual and the family members at the same time and can be used to indicate the entire effects of the dying process on all concerned. The loss of the presence and role of a
significant family member is sufficient enough to cause dysfunction and disruptions to the ways the family has known itself. After the death of a significant family member, especially in the nuclear family, the pattern not only alters but transforms into a new and different family unity. Satir, (1979) says that she perceives the process as a "family transforming in death" a term which imparts a positive connotation to the dying process. Schoenberg, (1972) states that even before the significant person dies stages of anticipatory grief are experienced by the family over the impending loss in the same way that Kubler-Ross, (1969) states that the individual may process through certain emotional stages before death.

Satir

Central to Satir's work is the concept that family therapists deal with family pain, and that family therapy must be oriented to family as a whole. Schvaneveldt, (1966) considered family as "unity of interacting personalities" indicating some difference from family as unit. As a unit, family tends to be perceived as an undifferentiated whole without respect to the individual members. As a system of unity, the concept of personality also remains a dynamic concept within the processes of family interaction. Family can be considered a unity of individuals involved in subsystems; diads and triads "supported and limited by
patterns of family life."

Families can be considered nuclear or extended, that is confined to the basic couple and their offspring or may include generational and ancillary members such as grandparents, cousins, aunts and uncles. Stryker, (1959) states that the family can be considered to be a pattern of shared and learned meanings and values. In addition Schvaneveldt, (1966) says that the family shares a symbolic environment of significant symbols that appear as isolated entities and in clusters. These shared meanings and values whether conscious or unconscious have a symbolic than for both the individual and the family group. Therefore, it is important in therapy with the dying to include both principles of psychodynamics and family processes. Satir, (1964) states that: "There was an essential relationship between a patient and his family. Any individual's behavior is a response to the complex set of regular and predictable "rules" governing his family group, though these rules may not be consciously known to him or the family. From this point of view, we can begin to stop seeing relatives' activities only as dangers, and look at them as forces for growth and indications of the power of interactional transactions." (P. IX-X).
According to the concept of family "homeostasis" (Jackson, 1954, Satir, 1964) referred to the family in action to maintain this balance in relationships, and when the family homeostasis is precarious, members exert much effort and energy to maintain it. (Satir's, 1964) terms the "Identified Patient" as it refers to the family member with the identified problem. The concept of "identified patient" carries the realization of the "unidentified patient:" the one who has the most dysfunctional behavior and attitudes in the family may not be the one with the "identified problem." So, too, with the dying. This researcher's observations are that often the dying person may not need attention and support as much as someone else in the family. The unstated psychological suffering of another family member other than the dying person may be a source of pain and dysfunction to the entire family and the dying process. Satir, (1972) describes:

"The major, natural common steps a family undergoes as the individuals grow within the family. All of these steps mean crises and temporary anxiety and require an adjustment period and a new integration. ...Finally, the tenth (step) comes when death comes to one of the spouses, and then to the other."

In this researcher's observation, these "steps" also in-
clude all members of the family and indicates the need for therapeutic attention to all. Therefore, as Satir says (1964; 1972) it is essential to take into account all family members, their roles, functions, rules and patterns of communication. To accomplish this Satir, (1972) says "communication is the greatest single factor affecting a person's health and his relationship to others."

Jung

In the dying process, there may be a heightened sense of intrapsychic family dynamics through increased receptivity to the unconscious activities released when the normal coping methods of everyday life are threatened.

Jung, (1959) posited a psychic existence that "can be recognized only by the presence of contents that are capable of consciousness. We can, therefore, speak of an unconscious only in so far as we are able to demonstrate its contents." Jung differentiated between the personal unconscious contents which are "feeling-toned complexes" and a collective unconscious which is a universal, in contrast to the personal, activity of the psyche and which "has contents and modes of behavior that are more or less the same everywhere and in all individuals."

It is from the collective unconscious that the archetypes are known in terms of images and/or symbols. (Jung, 1959) says "These images are 'primordial' in so far as they
are peculiar to whole species, and if they ever 'origi­nated' their origin must have coincided at least with the origin of the species. They are the 'human quality' of the human being, the specifically human form his activities takes." Jung says that the archetype itself is a possibility of representation, a principle, a determined form only and not the concrete representation that experience fleshes out. Jung, (1954) says that as in individuation, "there are numerous motifs and we meet them everywhere in mythology. Hence, we can say that the psychic development of the individual produces something that looks very like the archaic world of fable and that the individual path looks like a regression to man's prehistory."

In regards to the variations and varieties of archetypal themes and images Jung (in Strauss, 1964) says that "There are as many archetypes as there are situations in life." Through the enumeration of archetypes Jung's essay (1959) on the Mother Archetype, the Child Archetype, Anima and Animus and Marriage as a Psychological Relationship, the idea is derived by this researcher that archetypal energies can also form "families" or patterns of interaction that closely parallel the social formation of families. It appears that archetypal images and themes may parallel family interactional roles and mapping processes that occur in the family system.

This may become particularly true in the stress of the
dying process. Jung in Jacobi, (1959) says that, "the (archetypal) dreams occur mostly during the fateful phases of life; in early youth, puberty, at the onset of middle age and within sight of death."

To illustrate, some of the images and themes of death have been described in a variety of universal concepts: (Herzog, 1967; Von-Franz, 1976) the grim reaper, devouring dogs, dragons, witch mothers, harvested grains of wheat, snakes and birds, ghosts, and paternal relatives who are deceased, and night journeys to indicate only a few.

At the same time it is universally acknowledged that death is outside of conscious experience and that it appears to be total annihilation. As such death can only be imagined in symbolic or metaphorical images. It may be imagined as the opposite of consciousness, as darkness, silence, the incomprehensible, the unknowable and transformation. If death has a "nature", that "nature" may exert a pull into the dark unknown domain of death and unconsciousness. Hillman, (1978) says that dreams like death belong in the realm of the unconscious and can only be experienced in terms of its own images and motifs.

Grotjahn, (1971) says "images become symbols in terms of the secondary processes and function of the ego." It may mean that in dying ego functions are distracted from its defenses to confront hitherto unaccounted energies in the individual. As the social climate changes in regard to
the issues of dying there may be a changing attitude towards symbolism which may open increased alternatives to understand activities now outside of conscious awareness. Symbols and images may convey meaning other than the rational, logical constructs of the mind. Death falls into the category of the nonrational and may be apprehended only in the use of images that come from the unconscious.

In the dying process care givers are faced with dying individuals and members in a family system who are confronting the potential loss of that family member.

Jung, (1965) says that it is not the problem of the soul that death occurs, but how to relate to it.

**Other Theories of Importance**

There are some authors that touch both the concept of image and theme formation and the interactional behavior of families and individuals. Their works suggest a former orientation to the present study's suggested approach and merit discussion.

Stryker, (1967) says "language, basically, is a system of significant symbols." Stryker suggests that role and identities are influx as role relationships change and the changes should be taken into account throughout the stages of family experience. Symbol, then is essential to family life.

Kantor and Leher, (1975) focus on the image making be-
behaviors of families and state that "bystanders part has a three fold task of representing four major aspects of the family's meaning dimension; (1) The image of the outside or exterior culture (2) the family corporate image (3) the image of interpersonal subsystems and (4) the member's individual image heirarchies."

The authors, Kantor and Leher, continue their focus of family images with the reflection that they may be found in historic themes and are rooted in prototypic scenarios or strategies. Historic themes have the same kind of continuity as a novel plot and they connect families' histories with the ongoing process and with its destiny. Family themes dependent on perceived and shared images "regulate access to specific target themes especially those themes relating to each other." This statement indicates an important indication of possible archetypal images and the roles they take in families.

Kantor and Leher say that:

"Thus, not only are family strategies, including their embodiments of both present day and historical themes, eminently fascinating conceptual tools, but also they are the most instantly enlighting conceptual tools at the family analysts disposal." (P.62)

(Underscoring is researcher's emphasis.)
The therapist can be considered in the same light as the family visitor then the following applies:

"Largely by a transmission of images and non-verbal meta communications, but also by direct verbal communication, family members both assess their visitor and transmit cues of their own....in gaining further access, the visitor must locate the boundaries, or metaphoric walls, of the interpersonal system and find a way to cross them.

This thought applies to the methods a therapist must use in working with the dying and their families.

Hayakawa, (1953) also follows the thought when he states that there are verbal and visual symbols and they reflect on the data of daily experience and that "images, image clusters and visual stereotypes inside our head create a picture of the world." Hayakawa speaks of "New perceptions of the senses that create a need for new symbols to match our experiences. Symbols that are adequate to deal with the profoundest realities of the time."

Hess, (1959) in enumerating the essential processes that family therapy must take, includes: "2. establish a satisfactory congruence of images through exchange and 3. evolve modes of interaction into central family concerns or themes."

These authors indicate an observed need for the thera-
Rationale for Suggested Therapeutic Approach

The selections of Virginia Satir's Family therapy is evident in the fact that therapy with the dying and their families must become family therapy. All members are involved, as well as the dying individual. The selection of Carl Jung's archetypal theory is accepted as a lens to further deepen the understanding of dying families and individuals for the approach of death is an event that triggers heightened unconscious activity and releases images and themes into the families intra-psychic life. Those images and themes are meaningful and significant to the families adjustment methods to stress anxiety and crisis. Further, the use of archetypal images and themes offer theoretical concepts and clinical methods for consideration in the work with the family. Shniedman, (1978) concurs with this researcher that therapy with the dying is different than other forms of therapy. The presence of time is different than for others, goals are different, the rules of interaction between therapists and client are unconventional and the immediate values and goals are different. Gordon, (1978) says that the archetypal images or thematic activities in the dying process also may be
distinct and immediate. The demands for a specific therapeutic approach in the dying situation is different than in normal therapy; because of the twilight area between conscious and unconscious activity and behaviors that are observed in the dying process. It is this researcher's opinion that care givers must have a firm ground upon which to work.

This work attempts to form theoretical concepts and a clinical approach to the dying situation and the people involved by the use of both family therapy and the therapeutic use of images and themes in the understanding of family archetypal behavior. It may be that family therapy alone may not be sufficient to work with the dying and that, by itself, the use of archetypal images and themes also may not be sufficient. Family therapy may benefit by including archetypal images and themes as they reveal a dynamic role in family process, and therapeutic relationships to archetypal images and themes may not stand on its own without the benefit of placing them in a relationship to the environment and structure of families. Death in the family are neglected aspects of family study just as family process and symbolic meaning have been neglected in the care of the dying.

It may be necessary irregardless of the reluctance and ambivalence of some within the field of death and dying to have a systematized approach to working within this highly
profound and intense process. As Ackerman, (1956) states: "to do therapy without a conceptual framework is like playing in the dark, it may be fun at first, but very soon it leads to mounting anxiety and disorganization."
CHAPTER III

Omega Therapy

The Therapeutic Approach

INTRODUCTION

For the purposes of this study, therapy with the dying is seen as family therapy. The dying process involves the dying individual and affects the entire composition of the family as well. This may include friends and in some cases, pets. The dying individual does not die in a vacuum. The death of any significant family member is participated in and shared on some level by every family member. That experience may profoundly affect their individual and collective life as a family unit.

A therapeutic approach to dying is suggested by the combination of Virginia Satir's family therapy approaches and Carl Jung's therapeutic use of archetypal images and themes. Combined, those therapies become such a synthesis and maybe seem to yield a new therapeutic approach effective in working with the dying and their families. The focus of the suggested approach is on the family roles and patterns of communication, as well as on the shared archetypal themes and iamges as they relate to the process and images of death and dying.

In presenting the method of Omega therapy, this author
will: (a) discuss the concept and needs of the dying-transforming family, (b) discuss Satir's family therapy approaches and Jung's therapeutic use of archetypal images and themes, (c) outline the particular strategies of both approaches that are pertinent to the therapeutic work with the dying-transforming family (d) brief discussion of some suggested goals (e) discuss other therapeutic approaches that provide precedents for Omega therapy, (f) define the therapists role in the application of the new therapeutic approach (g) show how the suggested therapeutic approach works in the dying-transforming family chart and (h) chapter summary.

The Dying-Transforming Family

The dying-transforming family is the focus of therapy in the dying process. The term the Dying-Transforming Family is a term that includes the concepts, at one and the same time, of the dying person, the family members, the disintegration of existing family structure and processes, and the beginning of the transformation of existing family patterns to future, yet unknown, family patterns. The dying-transforming family will lose a significant family member when that member dies, and the surviving family member will undergo a profound change in its former patterns of communication and interaction, thereby transforming the dynamics. It is at this time of greatest
stress that the salient images and motifs of a family's psychological life are heightened and activated and seek ways of relating to the death event.

The International Workshop Group on Dying (1976) created a Bill of Rights of the Dying, a list of basic assumptions and related methods of treatment for the consideration of the dying. Among some of those assumptions that refer to psychosocial care are "the family undergoes serious change when the process of dying occurs within it; that the complex treatment and delivery of health care are disruptive for the patient and family; and that the respective life styles and philosophies of the patient and families are to be respected."

The Hospice concept for terminal care has as a basic premise that the patient and family are one unit of care. Hospice conceptualizes that the need for care of pain be done in both terms of the patient as well as the family. Implementation of such a concept begins with attention to the psychosocial needs of the patient and family.

The non-medical needs of the patient and family are termed "secondary suffering" (Weissman, 1972). This term denotes the psychosocial isolation of the patient which continues to exist following adequate control of pain. These secondary sufferings may come about because of the situations that the dying person may find himself in, such as: impairment or disfigurement; weakness, loss of control
of bodily functions; pain; physical isolation; social isolation and rejection; and economic stress. Secondary suffering (Weisman, 1972) is indicated by "impaired self-esteem; endangerment, that is regression, extreme denial, and projection; annihilation anxiety; and alienation anxiety, or the fear of separation."

The emotions that accompany the psychosocial or secondary sufferings have also been noted by Kubler-Ross, (1970) in what she considers emotional stages. Those stages are shock, denial, anger, bargaining and acceptance. These phases or stages need not be experienced by all dying people nor do they occur in a fixed sequence. This researcher has observed other feelings entering into the dying process as well - guilt, shame, betrayal, sorrow, weariness, confusion, helplessness, loneliness, grief and hopelessness. Shniedman, (1978) states that "there is a tendency (of the dying person) to premourn himself..." and Shoenberg, (1972) indicates the anticipatory grief of both the patient and the family creates real feelings before actual death occurs. Pattison (1978) catalogues the emotions of the dying under fears and identifies them as: "fear of the unknown; fear of loneliness; fear of sorrow; fear of loss of body; fear of loss of self-control; fear of suffering and pain; fear of loss of identity; and fear of regression." Thus, fear and the other emotions listed are strong emotions that occur in the dying trajectory of a
dying person.

Shniedman, (1878) states that "there is a tendency (of the dying person) to premourn himself..." and Shoenberg, (1972) indicates the anticipatory grief of both the patient and the family creates real feelings before actual death occurs. Pattison, (1978) categories the emotions of the dying under fears and identifies them as: "fear of loss of body; fear of loss of self-control; fear of suffering and pain; fear of loss of identity; and fear of regression." Thus, fear, and the other emotions listed are strong emotions that may occur in the dying trajectory of a dying person.

As the dying person suffers, so does the family. Sometimes the family members echo or parallel the emotional conditions of the dying person, at other times they lag behind or leap ahead. The family is affected in many ways. Maddison, (1972) cites that the family can react in three ways "(a) as individual members, (b) as a family group, (c) and as a family in its relationship to society." Maddison states the reactions depend on the pathological relationship of the individual to the dying person; the area of conflict mobilized; and the perceptions of the situation as the family may react according to several situations; changes in role structure; the concentration of the ill member; their understanding of sick role behavior; to the way their communication on patterns are changed and
modified; to the effect of hospitalization; and the presence or non-presence of an extended family." The involvement of the family's progress and dynamics in the dying process are thus confirmed.

**Suggested Goals**

One of the needs of both the family and the patient that requires attention is the issue of loss of control and identity.

Suggested therapeutic goals emerge with respect to the needs and problems of the dying-transforming person and their families. Those goals may be to finish business and to say goodbye, or to die an "appropriate death ... which is not an ideal death. Rather, an appropriate death is one that a person might choose if he had a choice." (Wiesman, 1972).

Such an appropriate goal may be in keeping with the intra psychic theme of the dying-transforming family and may only require sufficient recognition and address in order to accomplish finalization. Finalization of family and individual themes by relating them to the dying process is different than the therapeutic goal of "working things through" in that the goal is not for some expected future psychic condition, but that it is what is actually happening only in the present moment.

As psychosocial pain may also be an immediate reality
for the dying-transforming family, another therapeutic goal may be to rechannel such pain in order for that energy to be directed into the service of transformative processes that may be found within that family's existing patterns. Satir, (1979) emphasizes that pain must "go someplace" and that pain can be expressed and transformed. In the instance of the dying, psychosocial pain may be therapeutically useful when it is rechanneled into other behaviours and attitudes in the interest of growth and transformation.

Satir and Jung

Satir's 1969 - 1972 family therapy emphasizes the unity of the family and the interrelationships of individuals within patterns of communication and role expectations. Satir, (1964) says that family pain originates with the primary couple and then is reflected in the relationships of all the family members. In the family dynamics assumed circular pattern in family therapy, Satir emphasizes the concept of open or closed systems to define family, as it relates to change from the outside and she identifies four communication patterns: blaming, computering, distracting and placating. Mapping or reorganizing the connections is used as a method to help families understand their integrated roles within the relationships, the concepts feeling, thinking, hearing and understanding. Such a process includes the uses of verbal and non verbal
communication of the identified patient and family as clues to the family interior dynamics and role structure. The benefits of the Satir method of family therapy is that it takes into account all the observable behaviors and attitudes in a given family. In this study, instead of using Satir's family therapy primarily as a change agent, the objective is to use family therapy as the resource which enables the dying-transforming family to find strength and support within their own family system in the face of the dying crisis.

The therapeutic use of Jungian archetypal images and themes may be seen to efficaciously combine with the elements of family therapy in order to accompany that therapy with symbolic imagery that would further illustrate to the therapist the dynamics of the dying-transforming family. Archetypal images and themes are universal and general in their broadest sense, but have unique meaning and application for the individual and the family. Archetypal images and themes are best related to rather than interpreted. They emerge from the realm of the unconcious mind and can provide insight into the needs of the individual and shed light on the family's dynamics. Archetypal themes are found in each family's patterns and have meaning unique to their communications. Such images and themes provide the necessary language with which to speak with the family's shared experiences, meanings and
goals. The identified and non-interpretive use of the archetypal images and themes offer their own language with which to dialogue without changing the family's pace or engendering the defenses of the already stressed family.

Death and dying are clearly archetypal themes. Within those themes are variations of transformation, rebirth and passage. The images that are carried out within each theme are as many and varied as there are people, however, still fall into general, universal categories. The use of archetypal images and themes in family and individual life provides the caregiver insight into the dynamics of the family, their central conflicts, their images and expectations of themselves and their outside world.

Together, the Jungian and Satir models compliment and augment one another in the care of the dying and their families.

Satir and Jung Strategies in Omega Therapy

Omega therapy incorporates specific Satir and Jung concepts and operational components that may be seen as similar in principle and dynamic. The Satir therapeutic elements involved are (a) the family as focus of therapy and (b) the recognition of archetypal images and themes as motives and myths, and (c) an adjusted use of active imagination technique to relate to those images and themes. However, Omega therapy suspends the interpretative function
inherent to analytic approaches and rather attempts to relate to themes and images as they emerge as a constellation of energies (themes) and as the content representative of the energies (images). For instance, the theme of nurturing is usually accompanied by the image of mother. In Omega therapy such themes and images are viewed as components of the dying-transforming family. It is important to note that themes and images unique to each person are involved in the dying-transforming person. Some typical archetypal images and themes will next be examined and then related to approaches to family therapy. In the opinion of this researcher archetypal themes and images reflect "family" behavior in so far as archetypal energies or complexes tend to bond together and they give rise to one another, they may be mutually interdependent and interrelated, and that they may be found in generational patterns throughout families.

Archetypal themes generate symbolic images that accompany deep unconscious experiences. Archetypal images emerge from or are reflective contents of the dying-transforming unconscious activities. Because it has not been actually experienced, final death cannot be apprehended by conscious processes but rather only approximated by symbolic representations.

Many of the observed images and themes are derived from archaic, classical and cross-cultural sources in myths and
symbols. According to Gordon, (1978) the archetypal themes that center around the death event center on four general areas (a) change, growth and transformation; (b) union and fusion; (c) travel and distance; and (d) formlessness decay or dissolution. In Omega Therapy, (d) passage and initiations and (e) struggle are added.

Themes and images related to death tend to be multifaceted and fluid. Themes and images of life and death are closely bound and maybe arbitrarily divided into two major categories which subsume all six themes (a through d). They are (a) liberation and transformation as a positive theme, and (b) annihilation and destruction as a negative theme.

In the discussion of themes, these archetypal representations may reveal a process indicative of the dying-transforming family's disposition and orientation. Those same themes may be reflected in the family as changes in their ways of coping, their communications, dreams and activities of both leisure and work. The individual's and family's metaphors may begin to significantly alter and to reveal their inner dynamics and needs. Those metaphors may be detected and observed in the family's everyday speech, non-verbal communication and gesture, acting out behaviors, and in spatial and time arrangements.

According to Von Franz, (1976, 1979) those archetypal themes take on archaic and primitive tones, and may find
expression in the following (a) mystical marriage; (b) journey to the West; (c) visitation by the dead; (d) seeing one's double; (e) seeing one's corpse; (f) seeing a dying or dead animal; (g) the reaping of or decaying of vegetation and (h) the cutting of tress and/or dismemberment. In addition Gordon, (1978) added grasping or holding onto something or drowning, and Herzog, (1966) added killing. Elaide, (1954) added wandering in a labyrinth, and dance. In Omega therapy, loneliness and suffering are added as themes.

The preceding motifs are some of the most frequent archetypal themes that represent activity concerning death and dying and may be seen to indicate the manner in which the individual and family relate to the dying process.

According to Gordon, (1978) Herzog, (1966) Jung, (1968) and Von Franz, (1976-1979) those archetypal images that emerge from within the themes are (a) the Center of which the sacred city or sacred mountain; (b) travel – of which bridges, roads, and ship are symbols; (c) earth mother – of which caves, tunnels, earth, and water are symbols; (d) immortality, of which the indestructible stone is a symbol, and (e) heaven, for which the store house in the beyond is a symbol.

Additional representations which emerge from archetypal themes are mother, child, hero, father. The scapegoat or victim are also often present, which symbolize vulnerabili-
ity. Darkness and silence tend to symbolize death and the unconscious, which dance tends to represent initiation. Clocks usually symbolize time and its uses.

Of all the preceding images, mother, father, child, hero and scapegoat are variations of the more basic thematic principle of masculine and feminine images as Jung (1959) says are the animus and anima. Those images may be seen to represent the most common communication patterns found in family dynamics. Such images may represent both positive and negative prototypes for family roles and variations on those roles. For example the negative aspects of the mother may be images as the devouring earth, the she-witch, and possessor. The child image represents the innocent, vulnerable and small aspects of the dying process and may indicate new growth, as well as repression. The hero image may refer to the condition of the conscious mind and ego and may be imaged as saviour, restorer of order and balance. Doctors, medical staff, counselors and member within the dying-transforming family may be unconsciously assigned the "healer" role. Archetypal images and themes are images removed from the unconscious experience and emerge into the conscious mind in order for the conscious ego mind to relate to the activity of the unconscious.

Liberation and annihilation may be identified as two polarities between which themes and images exist. Any given
image of a theme may be at one time positive or integrative and at another time negative or destructive. The function depends on the conflict of image in relation to the psychological life of the person and his/her position and role in the dying-transforming family. For the purpose of lending consistancy to the following therapeutic schema (see Omega Therapy Schematic), Jungian archetypal images and themes, as well as Satirian communication patterns and family role, are categorized under the two polarities of liberation and annihilation.

It is important to note that the desired therapeutic goal of Omega Therapy is to assist the family involved in the death process to transform the annihilation themes and images along with the negative communication patterns into liberation oriented themes and images accompanied by constructive communication patterns. Successful transformation of themes, images and communication patterns is in great part dependent upon the archetypal material inherent in the family on the onset of the therapy.

As presented, annihilation and liberation themes are the two major themes within the Death archetype. It is therefore important to note that further associations of images and themes to the Death Archetype through the processes of annihilation and/or liberation appear to represent and imply an overall association to the Feminine Principle. Some association which represent the Feminine
are: death, darkness, chaos, moist, water, vegetation, formlessness, union, nurturance, earth, rock or stone, animals, moon, mother, child, daughter, fertility, harvest, caves, and the house. These representations are closely bound to and yet contrast to the representations of the Life Archetype which is implied by the Masculine Principle and tends to be associated by: order, light, son, Hero, God, Savior, discrimination, creativity, tradition, penetration, division, prohibitions, commandments, restraints and subversion. Life and Death Archetypal representations are closely bound and give rise to one another. Themes and Images common to both life and death emerge and can relate as if one were the shadow of the other. Such relationships are presented in Associations, page 53.

The code in the Chart for Archetypal themes and images used in Omega therapy tend to have the following association patterns.

The Mother: earth, water, stone, cave, house, night, darkness, devouring, witch, nurturing.

The Father: obedience to heirarchy, tradition, man made laws, works of art and craft, protector, organizer, the son, the hero, and God.

The Child: small, vulnerable, needing, new growth, synthesis of consciousness and unconscious, the future, new awakening, beneficial unconscious forces, protective, the
philosopher's stone, The Center.

The Hero: Magic, Savior, God, ego or spirit, guide, wounded healer, sun, light, the Son.

The scapegoat: victim, burdened, outcast, less than human, animal, rejected, unconscious, wounded, prey, ridicule, shame, guilt.

Such images and themes tend to be associated to the Death Archetype in ways either representative of either liberation and annihilation. Previously documented Archetypal images and themes are also particular representations in the dying process.

The codes for the communication processes and roles used in Omega Therapy tend to have the following associations.

The Blamer tends to feel angry: dictates, finds fault, bosses, accuses, disagrees.

The Placator tends to feel helpless and worthless and: pacifies, pleases, apologizes, excuses, agrees, and is over sweet.

The Computer tends to feel no feeling is detached and is ultra reasonable, collected, cool, correct, abstract, rigid and unconnected.

The Distractor tends to feel lonely and futile and: disorganizes, busies, is irrelevant, chaotic, aimless and without purpose.

The Identified Patient tends to be characterized by
feelings of guilt and shame and: whines, hides, escapes, and is the focus of the family in either a positive way as the "star" or "healer" in the family map or in a negative way as the "Problem" or "cause" of disruption in the family map.

These communication patterns and roles are usually found in a closed family system and are considered dysfunctional traits. A closed family system provides for little or no alternatives for change within its system and structure. Such closed structure and dysfunctional communication patterns may contribute to destructive behaviors and relationships. Such roles and patterns may be learned defenses and habitual protections against painful individual and family dynamics. These roles and patterns may also emerge in an open family system at some level or in some manner when the threat of imminent death occurs.

An open family system offers choice and acceptance for change and utilizes positive communication patterns that may be in contrast to those listed. Open family structures contain constructive communication patterns that are direct, clear, specific, leveling and congruent (Satir, 1972) and may be representative in roles of thinking, feeling, understanding, hearing and which may provide the possibility of developing an integrative function.

For the purposes of this study, Satirian categories of dysfunctional communication patterns and roles (Blamer,
Computer, Distracter, and Placator) are generalized and positively correlated to contrasting roles.

The Blamer may be related to a defense mechanism which attempts to compensate for feelings of inferiority, guilt, shame, anger, suffering and loss. The contrasting, constructive role may be said to be that of feeling one who is directly responsible for his/her feelings and behaviors and does not project the cause of his pain onto extrinsic people, things or events.

The Placator may be related to a defense mechanism which attempts to compensate for the feelings of worthlessness, frustration, loneliness, and loss of self-identify. The contrasting constructive role is one who listens, hears and tries to cooperate and unify.

The Distracter may be related to a defense mechanism which attempts to compensate for feelings of futility, hopelessness and alienation. The contrasting constructive role may be said to be that of one who can be specific, insightful, congruent and understanding.

The Computer may be related to a defense mechanism which attempts to compensate for feelings of vulnerability, weakness and depression. The contrasting constructive role may be said to be that of one who can think clearly and is strong and courageous.

The Identified Patient may be related to a defense mechanism which attempts to compensate for feelings of
rejection, betrayal and insignificance. The contrasting constructive role may be said to be that of one who is aware, conscious and integrated.

These generalizations of negative communication categories and correlations to potential positive roles and patterns provide a conceptual schema from which to accomplish a therapeutic process with the dying-transforming family.

Other Therapeutic Strategies

Other authors have oriented themselves in similar directions as this researcher and have set precedents for some of the proposed methods.

One of the identified needs for and problems of the dying-transforming family is the need for self-control and self-identity. Omega therapy suggests that the most appropriate response to that need is to conduct the therapeutic process in vivo, or in the original situation and environment of the family. Therapy with the dying-transforming family may best be done within the bounds of their own territory and may mean that, if the dying person chooses, the home is the most beneficial place within which to die. Ardrey, (1966) states that "territoriality" is the focus of power and energy for biological creatures. The concept of territoriality provides a maximum secure environment to the owner. Such a safe and familiar environment may enable
the owner to safely express such multileveled dynamics as are found in individuals and group behavior.

Kanton and Lehr, (1975) say that "family must be studied in its own natural geographic and social context rather than in the professional office or laboratory. The natural environment provides the richest possible context for family study." (pp. 102-3)

The home environment in the care of the dying-transforming family may become a psychosocial advantage for the family already coping with unexpected stresses, situations and processes. Home territory remains a familiar, sustaining environment replete with the objects, artifacts and patterns of normalcy that reflects their personalities, realities and dreams. The home territory also may be more immediately accessible to family members, friends and pets than an institution, and may be, therefore, a place that reduces the social isolation and alienation inherent in the dying process.

Home territory can become an valuable way for the therapist to focus on the everyday, common place family dynamics, and the most appropriate place to gather information about the family's images and themes. Friedman, (1970) says that direct observation of the family in the natural background of home "can bring into quicker focus the significant dynamics in the life of the family and can guide treatment; can observe how family interacts with the pa-
tient and family patterns; and indicate family processes in the behavior of animals and in the reflection of the politeness of friends." Friedman also states that "observation of behavior in relationship to family pets can add to the understanding of family libidinal relationships and other family dynamics." As Friedman states, material that also provides clues to those dynamics are related to feeding habits, issues of cleanliness, issues of dress and of bathroom and bedroom behavior. Omega therapy observes that spatial arrangement, color, choice of style of furniture and artifacts and books also indicate the dynamics of family life. It is important to be aware that such environmental indications of family life are not dependent on economic status, rather that the resources available have specific meaning to the dying-transforming family.

Berman, (1973) adds further to the discussion in favor of home family therapy by saying "one reason that the family research may be empty and devoid of intimacy is that the western and especially Middle American families have not been studied inside their natural habitat - the home."

Faberstein, (1978) and Bell, (1978) also cite that importance of environment. Faberstein cites that "images or places reflect personal needs and uses ... as a need to express the self.." and that dwellings "present a mental map about the interior world" that the home or dwelling he says give messages or communication about the occupants and
that boundaries and connections, politics and conflicts uses of energy can be observed. Bell says that behavior and environment are interchangeable and have effect one upon another. Omega Therapy realizes the importance of observing all the connections, patterns and expressions in the dying-transforming family's life as it is expressed in the concrete material world. Therapy in the home can also be a way to restore a sense of control and identity to return to the family and individual. Those images and artifacts that are present in their surroundings remain meaningful to the family and individual and may ameliorate the loneliness of the dying process. The personal expressions also can be significant images that enable the therapist to quickly assess the dominant, meaningful themes and patterns of the dying-transforming family.

Images and the themes that emerge from family interaction may provide a useful therapeutic clue to understanding the deeper intra psychic images that come out of the fabric of the dying-transforming family's dynamic life.

Some authors have stated a concept for the therapeutic use of images and symbols, and have operationalized the use of images in a therapeutic method. Gordon, (1978) in speaking of dying individuals and the use of imagery in Rorschach testing says that there is a predominance of certain characteristics. They are "fewer large detail responses, fewer pure form responses, looser sequences and
freer use of fantasy and activity." This statement concurs with Omega Therapy's observations that the dying, and their families frequently use language and non verbal communication to indicate mode of experience and perception more closely connected to the unconscious. Gordon further states "the subjects ego function of reality testing had become less important than the emotional and imaginary events that were going on inside them," and that "conflict ridden and highly affective contents may be expressible only in terms of symbolic equation, or... they may be expressed in primitive, archaic and archetypal image forms."

Omega therapy uses the archetypal images and themes as presented by the dying-transforming family as the core of the method. The use of active imagination in Jungian therapy are precedent to Omega therapy and are also explored by Marjula (undated). Active imagination is the use of dialogue with contents of dreams as if those contents were personified actions confronting the individual. Hanna, in Marjula, states that the use of active imagination "establishes a balance between consciousness and unconsciousness," and that "it is the things given them by their own unconscious that make a lasting impression." Gordon, (1978) also addresses active imagination by saying that "active imagination is a valuable relation to issues of transference and counter transference between client and therapist. In the work with the dying-transforming family
images of transference phenomenon may be a useful and therapeutic reality not to be shunned.

Kantor and Lehr, (1975) are strong advocates about images and family therapy. They say that "the intensity of conviction behind family images is the key issue," and that one must "identify the amount of energy or push behind each of its meanings." Also that "there will be an icon in the family's space to symbolize a family's highly energized meanings."

Kantor and Lehr state that thematic archetypal representation in families can also be observed as generational, ...

...parents tap a memory bank of foundation images, generated by shared family experience, to identify just what target... without such an imaginative memory bank capable of storing impressions of both family and individual traffic patterns, target assessment would be less predictable." (p. 227)

Archetypal images and themes are both generational and active in family's processes and dynamics and offer much ready content information about the life observed of the family and its members. Omega therapy uses such generational themes in order to assist the family to finish its unique, particular business.

Shniedman, (1978) states that "working with the dying is a special task" and that there may be important conceptual differences between ordinary psycho therapy and with dying person. Shniedman calls the special situation the "thanatological situation" and says that the dying person,
not the thanatologist introduces the topics of death and dying because they may be uppermost on the mind. He further states that "the distinction between conscious and unconscious meaning is complicated in the dying scene by the very irrationality of death itself."

Shniedman, (1978) talked of a dying person's train of thoughts that go "off the main tract that leads to blackness and mystery," and that there may be a sudden radical change of pace that speaks of being well or doing something specific. He states that such a change indicates denial.

Omega therapy, however, acts on the assumption that such changes of pace and talk that encourages images of life may not be denial but the language of an archetypal theme seeking a language expression in order to finish business, and as such should be dialogued with and respected. Omega therapy believes, as Shniedman, (1978), that "from the psychosocial point of view, the primary task of helping the dying person is to focus on the person... on a human being who is a tiring behive of emotions including (and especially) anxiety, the fight for control, and terror."

The Therapist's Role in Omega Therapy

In addition to the Satirian (1967) definition the family therapist's role which stresses the interactional nature of the relationship between the therapist and
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<tr>
<th>THEMES</th>
<th>IMAGES</th>
<th>PATTERNS</th>
<th>ROLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Formless</td>
<td>decay, vegetation, clock(neg.), animals, labrinth</td>
<td>(1) Chaos, disorganization, denial</td>
<td>Distracter, denial</td>
</tr>
<tr>
<td>(2) Separation</td>
<td>terrible or devouring mother, journey, distance</td>
<td>(2) Anger, attack, lost</td>
<td>Blamer, denial</td>
</tr>
<tr>
<td>(3) Struggle</td>
<td>water, clinging tree, clock, Hero</td>
<td>(3) Depression, control</td>
<td>Computer regression</td>
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<tr>
<td>(4) Drowning</td>
<td>victim, silence, water</td>
<td>(4) Equivocal, grasping</td>
<td>Placator</td>
</tr>
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<td>(5) Dismemberment</td>
<td>victim, scapegoat</td>
<td>(5) Obsessive, whims, &quot;going to pieces&quot;, shame</td>
<td>Identified, Patient</td>
</tr>
<tr>
<td>(1) Fusion, Union</td>
<td>great mother, marriage</td>
<td>(1) Nature, comfort</td>
<td>Placator</td>
</tr>
<tr>
<td>(2) Initiation</td>
<td>dance, bridge, seeing one's double, Hero</td>
<td>(2) Assurance, trust</td>
<td>Blamer</td>
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<td>Passage</td>
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<td>(3) Change</td>
<td>The Child, harvest or reaping, indestructible stone</td>
<td>(3) Calmness, peace</td>
<td>Distracter</td>
</tr>
<tr>
<td>(4) Announcement</td>
<td>visitation of the deceased, Hero, light</td>
<td>(4) Integration, assimilation</td>
<td>Computer</td>
</tr>
<tr>
<td>(5) Time</td>
<td>storehouse in the sky clock, dance, ritual</td>
<td>(5) Awareness, wholeness</td>
<td>Identified, Patient</td>
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client, the Omega Therapist accepts the intensity potentially inherent is transference and countertransference processes as valid and appropriate therapeutic experiences and tool in counseling the dying. The therapist may take on the positive transference image of Hero, Savior, or Healer or may bear the projected negative image of a Terrifying Unknown Visitor, Avenger and Devourer. It is important for the therapist to acquire a distancing method or perspective from those roles in order to dialogue and not identify with either the positive or negative projections.

The Omega Therapist may also develop strong feelings about the dying individual and family and may temporarily carry some of their unconsciously projected burdens. She may develop imaged responses about the dying transforming family that bring her personal energy into the family dynamics. At this point in development of transference and countertransference the therapist will need to allow for such an emotional energy exchange. In order to discharge some of those energies she may find it beneficial to share the appropriate feelings with the dying-transforming family. Here tears, sadness, grief and sometimes anger are permitted emotions and may be expressed. Such an expression of appropriate emotion requires the therapist's personal authenticity and congruence as well as the ability to be flexible and to assume roles with the dying-transforming
Within the context of current trends towards holistic health care, Satir, (1979) indicated that she felt that an examination of the role of the Omega therapist should include attention to the following key issues (a) a "real" orientation to life and the living process; (b) an awareness of the potential for personal spiritual material to be present in therapeutic interaction; (c) a conscious connection between facilitating the death/transformation of others and of the therapist's self and (d) attempt to assist clients to let go of stultifying defense patterns or habits which may be preventing them from risk taking and truly living or from "truly" dying/transforming.

In order to shift from one accustomed therapeutic mode of operation to another flexibility is a requisite. Such shifts may require the Omega therapist to perform different but equally appropriate functions. For example, a therapist sometimes acts in the capacity of a friend, social worker, or care giver as the appropriate situation arises.

The need for flexibility also extends to the therapeutic capacity to hear and learn the various and different languages that dying persons and their families may use and to trust and use her own imagination to understand that language and respond in kind. She must be open to experience as time, place, conditions and persons may be varied
and inconsistent at every meeting.

The therapeutic use of images and themes as a language for dialogue with the dying and their families also includes those themes and images that are also part of the psychic life of the therapist that she brings to the situation. Omega therapy perceives the dying process to be an interactional process between the dying person and the therapist and from which both parties benefit. The therapist may be an active participant in the dying processes by her ability to address the issues of life and death (as imaged as light or darkness) as they may relate to her own life mythos or images. By her very presence in the dying-transforming family, the therapist's own image making ability may affect that family in a reciprocal and interactional manner. Such an interaction may result in the dying-transforming family including the therapist in their family map -- roles and communication patterns.

The Omega therapist serves as a resource person and one who models constructive patterns of communication with family members related issues of the dying process and related to their behavior. The therapist facilitates open communication whenever possible and does not become a message carrier between family members. At all times she encourages family members to complete their emotional and spiritual business with each other so that they may perceive themselves as doing all they can do for their
significant other when confronted by events of the dying process.

The Omega Therapist in most instances is not afraid to use touch with those members of the dying-transforming family. Touching in a stressful situation can be a hand on someone's hand, a touch to the shoulder, a small hug or infrequent light touches to someone's arm while talking. The Omega Therapist uses such touching in a warm, relaxed and unselfconscious manner, pays careful attention to the nonverbal signals from the individual that she touches in order to observe indications of possible relief, comfort, acceptance or denial or rejection.

Above all, the Omega Therapist must be able to function with a high degree of ambiguity, for the images of the dying-transforming family may shift and change, the dying process may remain uncertain and the individual and family may be regressive and in various stages of denial or depression from day to day.

In Omega Therapy, goals are often blurred and changed into immediate agendas in which the only goal is the present moment. Such immediacy relies more on therapeutic process than on establishing goals and may be satisfying in that there may not be usual signs of effectiveness in the therapeutic interaction.

For the therapist, ambiguity experienced in the dying process may extend to the post death period in which the
therapist's own grieving processes may frequently be connected to uncertainty about achieving the perceived therapeutic goals with the deceased.

The Omega therapist must at all times be watchful and conscientious about signs of stress and should take systematic and routine measures to prevent burnout. Such measures may be meditation, exercise, time off, hobbies or any activity that furthers and enhances the "centered" or integrated quality the Omega therapist must have.

The Application of Omega Therapy

In the application of Omega therapy it may be necessary to bear in mind that all individual families have a certain archetypal theme or mythos which they carry out in the conscious world. Those Mythos are unique to each individual family although they may share in certain overall themes. For example: healing, conquering, underdod or creating.

In treating dying-transforming families the therapist will concern herself with the mythos of the dying-transforming family's through the observations of themes and images that are bourne out in the totality of that family's life style and patterns of interaction and communication, roles, rules and environment. Specific indicators of those themes and images may be found in the family's dreams, specific fixed concerns and interests, gossip, stories about themselves, repetitious behaviors,
disjointed comments, uses of silence and absences, and metaphors as seen in expressive behavior such as hobbies or sports and in language.

The language used by the dying-transforming family is the common language of their mythos, and in the potential stress of the dying process and event the rigid rules of everyday communication shift into the freer, more associative mode, and begin to reflect the deeper dynamics of the dying-transforming family. The metaphors used by the interacting family members may be observed in the following ways (a) as primary communication -- direct, straightforward talk; (b) secondary communication -- indirect talk, which distances the communication from the actual meaning and (c) symbolic communication -- talk using only metaphors and symbols to communicate the actual meaning.

The Omega therapist must be aware of the common language most used by the dying-transforming family in order to understand the relationship of the family's archetypal images and themes as they relate to the family's dynamics. The family themes and images provide a common language and may be found in the following: street talk, slang or jargon, childhood language, common discourse, religious, scientific or technical exchanges, and literary metaphorical images. Omega therapist need not look for mysterious or arcane symbols or phrases in the communication of the dying-transforming family because people reflect archetypal
images and themes in everyday talk. The style of talk and non-verbal meta-communications reflect those significant themes and images. In treating the dying process, the therapist need not interpret themes and images because they are direct representations of the unconscious process related to the dying-transforming family process. At this point in the dying family's life the images and themes are best dialogued with and related to the dying process in the same way the family's roles and individuals are related to in family therapy.

Dialogue within those themes and with the images first begins by identifying the style or styles of language used by the family as stated above. It is important to note that if more than one style of language is used within the family's communication system that there may exist two or several major themes at work in their dynamics. Any potential or manifest conflict, conscious or unconscious, that may ensue from those different themes or motifs may greatly affect the manner in which the individual may or may not suffer and dies as well as the way the family grieves or such a conflict may be related to a significant dying process and may become threatening to the family system.

Once the language is identified, the Omega therapist tries to conform her communication to the same style of language the family uses, and does not interpret those
styles into another style or idiom. In order to acquire the style of language that might be different, the therapist asks for clarification and amplification of the ideas contained in the language and tries to respond in kind. Once a feel for the style of language is acquired the therapist listens to and observes the way problems and feelings are presented, who says what about whom and what events, who is present around the individual, who relates to whom in the family, which members are most and least accounted for, excused, and/or talked about, who sits where when the family and therapist are gathered, who relates more readily and closely to the medical aspects of the illness, the behavior of pets, the presence or non-presence of friends, who initiates topics in conversation, which common activities are kept and dropped, uses of home environment, space and energy patterns, congruent or incongruent content and process messages and who appears frightened, at ease with or obsessed with the idea of death. The age of the family and the age of the dying individual are crucial variables that may also indicate the themes inherent in the dying-transforming families specific situation, conflicts and stresses. These observations provide the map or schematic of family strategies for the therapist to understand and formulate a mode of relating to them.

The therapist relates to those themes (if any) and
images (roles) in an abbreviated and altered method of active imagination, that is by talking directly to and with the images presented by the dying individual or family members. For example, if in the course of a conversation the dying person suddenly leaves the normal flow of talk and appears to have changed the subject by talking about getting better and going on a trip and wearing a new outfit, the therapist does not immediately try to reality test for denial but goes with the sudden departure and allows the fragmented dialogue to follow its own course in its own internal logic. It is not the task of the therapist to always remind the individual or family of the underlying crisis and death reality but to allow for the discharge and expression of that person's remaining feelings and images in order to facilitate for the dying-transforming family a relationship with those images and themes. Such a relationship to those images and themes may allow them to carry out the mythos of their lives and relate that mythos to the death event in a meaningful way.

Such a dialogue in the active imagination mode somewhat resembles a psychodramatic technique of role playing. Identified images may be related to in the context of family language as if they were real and present in a way similar to the family members. The therapist talks to those images, as presented by the family, as if that image perceived by all those present. In order to do that she
may exaggerate and elaborate upon given statements that may indicate the activity of any archetypal image or theme. The therapist temporarily suspends, with the individual's permission, the "real" person and the "real" or stated problem and says that she wants to talk about something else that the individual has brought up. That something else may assume a parallel to the "real" problem and by analogy, storytelling (or story reading) suggestion and a mild form of play or pretend the therapist focuses on the images and the theme that the dying-transforming family has presented about themselves and enables the family to engage in a non-threatening relationship to their mythic images and themes. It may not be necessary for the individual or family to become directly conscious of their images. Often the most efficacious therapeutic results are that the family simply feel the effects of such a dialogue and begin to develop a relationship to the once frightening or awesome images of death and transformation in themselves and as they relate to other elements in their psyches. Such a method at once desensitizes the family individual to the potential threat and paralysis of death in their lives, distracts the ego function from a mobilization of defenses against new therapeutic suggestions, their own new images, and gives permission to the individual to engage in behavior other than what they are accustomed (as habit, custom or complex). As such a communication is initiated by
the therapist a model or pattern may develop for the family
to further explore a relationship to their own images - and
therefore to themselves - in the dying-transforming process
in order to finish business and say goodbye to the dying
individual.

In the application of Omega Therapy it is important to
encounter silences as a therapeutic process. The sharing
of silences with the dying individual and/or family members
is a profound metaphor or space-time image of death.
Theravadin Buddhists practice a meditation called Darshan in
which two people sit in silent contemplation of each
other's energies for a period of time. This ancient medi­
tation provides a useful method of relating to the dying
individual and to the dying processes, as it may suspend
many active ego functions and provide a shared intimate,
non-verbal and image releasing communication. (Finally,
the sharing of silence needs no further interpretation or
activity, for silence is an experience of itself to no
further end.) The sharing of silence may be especially
useful as the dying individual grapples with the realiza­
tion of her mortality as well as when she has come to
accept it and when the dying individual and family are in
the last stages of the dying process.

Omega Therapy in all its applications can be undertaken
in any setting or location. It is best done in the home
environment with the dying person present, but can effec-
tively be applied, for example, in the hospital, park, yard, car, office or coffee shop.

Normal initiation of Omega Therapy begins with an intake visit to the dying-transforming family that may be from one to two or more hours. The family is recognized as a unit at the onset of Omega Therapy. All members of the family, present or absent, must be taken into account as well as a brief description of family history in the past generation.

All family members and often generational history constitute part of the dying process as represented in the Dance theme. In archetypal representation Dance is seen as sacred and initiatory and involves the family group as they join in the Dance step or pattern of the dying individual. Friends, pets and care givers, as well, at the time of initial interview, are all perceived as participants in the Dance. For intake form, see appendix.

Summary

Chapter Three has presented the major limitations and needs of the dying-transforming family, and related them to the new therapeutic approach called Omega Therapy. Omega Therapy incorporates salient methods and concepts of Satir and Jung in a synthesized approach to therapy with the dying and their families. Those methods are the Satirian method of regarding family as a system unit of therapy and
observing communication patterns and roles within that unit and the use of Jungian concepts of archetypal images and themes as they relate to the family and the dying process.

Omega Therapy conceptualized the connections between the Jungian and Satirian components and illustrated the therapeutic concept in a chart.

Chapter three acknowledged other therapeutic strategies that may have preceded therapeutic components of Omega Therapy and has acknowledged the therapist's vital role in Omega Therapy. Finally, discussion of the application of Omega Therapy was made with emphasis on the technique of addressing the images and themes in the family's own language in order to accomplish the goals of finishing the family's life business and saying goodbye to the dying individual. A suggested intake procedure was mentioned and an intake form referred to in the appendix. It was suggested that the archetypal theme of Dance be accounted for in the initial intake with dying-transforming families. Chapter five will present five case studies and their representation of Omega Therapy.
CHAPTER IV
METHODOLOGY

Outline of Chapter

Chapter IV contains: (a) introduction to case study; (b) the justification for the use of case studies; (c) the research question; (d) the variables in the case studies at hand; (e) a rationale for the selection of cases; (f) case study procedures; (g) the method of data collection and recording; and (h) the findings.

Introduction

Omega Therapy - the methodology employing Satir's therapy approach and Jung's archetypal images and themes to therapy with families involved in the dying process has been documented in the review of the literature. The goals of Omega Therapy are to diagnose the dying-transforming family systems by observing and working within the: (a) verbal and non-verbal communication patterns comprising the family system; (b) the family map and roles within that map; (c) the images and themes that dominate the family pattern; and (d) to help accommodate the existing patterns to constructively assimilate the dying process.

Description of Case Study Methodology

The case study approach was selected as appropriate for this thesis because it lends itself to indepth study of a
person or unit such as the family. Additional purposes, characteristics, and strengths of case and field study research which support the use of this approach are documented by Isaac and Michael, (1971). The purpose of case study is to explore intensively an individual, group, institution or community in terms of its background, current status, and environmental interactions.

Case studies can give a total, systematic picture of a particular social unit as a result of an in depth investigation of that unit. An entire life cycle may be studies or only a selected segment, depending upon the purpose at hand; either specific factors of the social unit or a totality of elements and events may be emphasized. Usually, a case study examines a small number of units across a large number of variables and conditions.

In the case of this study the social unit is the family and we are studying a segment of family life within the context of the whole life cycle. We will be looking at such specific factors as communication patterns and roles and the symbols of images and themes. We are looking at time units with many variables and they are reflecting the foregoing communication pattern areas.

Case studies have a number of strengths. They provide useful background information for future major investigations in the social sciences. Often, important variables, processes and interactions are brought to the surface which
demand more extensive attention. Case studies also provide sources of future hypotheses for further study.

In the instance of this study we hope the findings provide implications for further research. We believe the variables of themes, images and communication patterns and their relationships will emerge and may be a source of hypothesis for further study.

Hess, (1959) adds to the support of the case study approach in research similar to this innovative area of study when he stated:

"case studies have, perhaps, a particular usefulness when they deal with problems at the forward edge of an area of investigation. They make it possible to illustrate in detail the referents of new concepts and think about their remifications.... A group of cases serves to keep concepts closely related to the events we wish to understand."

Of course, any approach has potential pitfalls. Isaac and Michael, (1979) document the weakness in the use of case studies: (a) they tend to have a narrow focus on a few units and findings are thus limited in their general ability and, (b) they are particularly vulnerable to subjective bias; therefore, it is imperative to keep in mind that valid generalizations cannot be made until follow up research is done which employs hypotheses and use appropriate sampling methods.
Research Question

In this study, the research question under examination was - can a viable and useful psychotherapeutic model for conducting therapy with dying-transforming families (Omega Therapy) be generated by combining the Saterian family systems approach and Jungian themes and images approach in an analysis of selected case studies?

Case Study Format and Variables

In the present study, families were observed and interacted with in a therapeutic manner over a period of time during the dying process of a family member. Existing communication and coping strategies were observed and utilized in order to provide psychosocial support and to enable the families to cope with death in more constructive ways. In addition, another therapeutic goal was to enable those families to finish business with each other and to say needed goodbyes. The independent variable in the therapeutic process was the death, the dying event itself. The dependent response variables that related to that event were the images and themes that emerged from the family structure.

Selection of Cases

Families were accepted into therapy in so far as they met the requirements of the Hospice criteria - (a) that
they be willing to receive support, and (b) that the dying individual be considered to have an illness which would probably result in death within six months. Family members were present at irregular times and family exchanges extended over varying periods of time.

**Intake Procedure**

Families were contacted after they had been either referred by their doctor or they themselves called. The initial intake visit was for the purpose of gathering family history. The initial visits were made in the family's home, usually in the presence of the dying person. First the therapist allowed the members to talk as much as they needed to after history taking. History taking included how long they had been ill, what the doctor had told them about their illness and how they felt about it. Free association among family members or by the individual in conversational tone provided introductory information about the sources of their conflict and their chief concerns.

As therapy progressed in subsequent visits and as death became more imminent, the images and themes, as well as communication patterns in the family, became more intensified and the therapist or therapeutic team worked within the parameters set by such themes, images and patterns in an effort to relate them to not only the dying process but
the eventual loss and transformation of their family processes and dynamics as well.

Family members were seen together as much as possible and sometimes apart. The therapist at all times encouraged a shared discussion of the events and feelings that were occurring within the situation. Where there was no ability to do so, the therapist worked directly with the images and themes at the individual's own pace.

As the therapist became aware of the dying process in the family and observed the reactions of the family members, the therapist noted experiences that were recorded to serve as therapeutic guidelines. A check list of important elements to consider at intake and throughout the course of Omega Therapy evolved (see appendix p.1). In the experience of this therapist, it seems that it is during the very first session that much of the material emerges that will reoccur throughout the therapeutic process – thus emphasizing the need for systematic intake procedures accompanied by periodic review of the status of archetypal themes/images and family communication patterns. It is from such a therapeutic approach to the dying process which incorporates analysis of archetypal themes and images, along with family communication patterns that the therapeutic approach named Omega Therapy evolved.
Data Collection and Recording

Data was gathered from actual therapeutic sessions with dying-transforming families. Information was recorded in the therapist's notes and in progress notes kept for the Hospice. Due to the sensitivity of the process, data was recorded immediately after the sessions. When a team approach was employed, consultations with team members were also recorded and provided data when needed.

Case Studies – Findings

For the purposes of this research, five case studies are reported and presented to demonstrate aspects of Omega Therapy.

The data from these case studies will be presented in the following format:

A) Family demographic data, including
   1) ages
   2) religion
   3) education level, background
   4) how long in area
   5) recent losses
   6) number of children
   7) are parents still alive
   8) income
   9) occupation
   10) type of illness
   11) treatment used, if any

B) Description of sessions over time until death:
   interactions, observation and dynamics (provides therapeutic progress).

C) Evaluations of each case (archetypal themes, images
and family communication patterns). Data was derived from therapeutic intervention with five middle socio-economic class families whose size ranged from two to six members and whose ages were from forty to seventy.

D) Findings will be presented.

Dominant Archetypal Theme: The Marriage

W Family
Age: 70
Sex: Male
Diagnosis: Cancer lung, spine, metasis
Education: college degree
Length of care: two weeks
Occupation: artist
Religion: none formal

Spouse: Mid sixties
  Occupation: artist
  Education: some college
  Religion: none formal

Age of family: 20 years
Family's structure: semi-open, nuclear, wife has child from former marriage
Recent losses: none
Family's present at intake: wife

Role code: B = dying
  W = wife
  D = daughter*

Role symbol connections-map
B to W = husband to wife as Placator
W to B = wife to husband as Blamer

Role communication, Archetype:

B = silence - Placator
W = great mother - Placator

* little observable connection

**Therapeutic focus:** evasion, anxiety

Initial contact by phone from wife who wanted to know about types of care available. W is evasive, vague and "spacy" in replying to questions. Her husband is "ill" she says, and she may need care at home for him. Says he is in some pain, but she keeps him healthy with vitamins. W hemmed and hawed about an initial visit and an initial visit time was booked. Two days prior to the scheduled appointment W cancelled. Said it wasn't for her; sounded cold, abrupt.

**Therapeutic focus:** denial, pain, anxiety, restlessness;

**Journey**

First visit: nursing intake with brief attention to psychological needs of wife, W, and patient, B. W indicated a good friend told her to use Hospice for medical care, as to make B more comfortable. W nervous and skitterish about giving specific information and said they had been in Mexico for laetrile and natural foods treatment. W added they had some radiation, too. B said he had pain in one leg. W says she administers coffee enemas and megavitamins. Says B will get well. W appears weak, thin, grey and also not well. She cannot sleep. They are adamant about no hospitals or surgery. B smiles when
addressed but appears weak, uncomfortable and depressed. B defers permission about further visits to wife who assents. House cluttered with many paintings, sketches and has a natural, eclectic and sparse look to it.

**Therapeutic focus:** denial, acceptance

**Second visit:** B is moved into living room from back bedroom. B has frequent friends visiting. Had been wanting to finish painting that lay to one side of room. B keeps looking at it. W gave vitamins and urged him to try to get well so he can finish his work.

**Therapeutic focus:** pain, anxiety, nurturance, denial; Great Mother

**Third visit:** B in greater pain - now in back. B moaned and groaned into pillow. W appeared to be concerned only with his not eating. She did not acknowledge his pain directly, but is nervous and taut.

**Therapeutic focus:** anxiety, why me?

**Fourth visit:** Doctor visited, prescribed pain medication. W said they didn't want drugs at first but B begged to have something for the pain. W appeared upset and distracted by him being in pain. Wondered aloud why he should be in pain.

**Therapeutic focus:** bargaining, avoidance support

**Fifth visit:** W wanted to try all alternative channels for B's care and hoped to take him off medication. Appeared again to want to block out his pain. Emphasized other
natural foods – uses of chiropractor, meditation. Denial was so heavy therapist wondered if they really know what was happening. When asked, W says she knew it was a serious illness. W's sister present and supportive of W. Sister was to spend time with her. Sister also avoided speaking about B's dying. W talked to spiritual pain in general terms.

Therapeutic focus: anger, rejection, denial, guilt; Decay, Visitation

Sixth visit: Doctor explained B is actively dying and insisted W stop all active treatment. It appeared to shock her. W wanted B to "wake up" and doctor to start intravenous feeding "so that I can talk to him". W tried to get him to eat, worried that he was not. B refused W's attentions to get him to eat. W appeared angry but held it in. Daughter present and supportive but also said nothing about B's dying. Visitors who are close friends coming regularly. It appeared this is first time friends knew B is "so sick". W vigorously denying and fighting B's dying. "I will not, cannot accept it", she said. She appeared guilty she cannot do something to make him well. "B can get well if he really tries". W told about a spiritual guide who was "healer". W told of B's experiences that have come to direct their lives. B had a spiritual experience she said and appeared wary of therapist's reception to such a statement.
Therapeutic focus: weakness, denial, nurturance, acceptance, finished business; Liberation, Light

Last visit: B cannot talk but responded non verbally to everyone that comes into room. W lights a candle beside his bed at which he often stared. W put Eastern music on stereo and lights a fire in fireplace. Talked of B's "spiritual guide" that B had visions of and who inspired him in his work. W placed unfinished painting where it could be seen by all. The painting was an abstract oil canvas that looked to be both destruction scene or a wreck with two figures emerging out of the center. All who viewed it seemed to see the figures of mother and child. Neighbor friends leave and the man said "See you tomorrow and we'll have you on your feet in no time." B smiled weakly in response. All friends left and a couple of W's favorites remain for entire period. Therapist sat facing B and engaged in eye contact. Therapist sensed strong need to have something done. B continued to search therapist's face and look straight and deeply into her eyes. Therapist says "yes" aloud to unvoiced question she sensed from B asking if he was dying. B only looked this way at therapist for an undetermined period of time. Comfort measures given. B weaker, cold. W never left the room and tried to give him water on a spoon. B tried to take it with much difficulty. Frequently W turned to the candle and stared.
Therapist sat beside B near head and watched W facing him. She was strained and disbelieving. She had earlier asked if therapist thought B was dying. Therapist now sensed something holding B back. Therapist looked at B and he seemed to want something from her. Therapist looked at positions in room and on bed and addressed W sitting in front of B saying that B wanted to know that you will be able to take care of yourself. B's eyes looked to W and entire body seemed to relax. W replied to B without looking at therapist that she will. Therapist asks if she will continue her art work and profession. W replied to B that she will, that it had been their life together. Therapist asked if W can say goodbye to him. W remembered to him times they had together and how there were good and bad and what they mean to one another and will always mean. W said she has faith in him and loves him. W puts her hand on his head and says "I love you. Go with God." B released a long breath, his body going cold quickly and he turned his head to the candle again. Within minutes B went to death. It appeared that B chose and was not "taken" by death.

After B died, W laid her head on his chest and cried for first time. Therapist left her alone. W later sketched B's death face before he was taken from home.
Evaluation

The W family operated as a semi-open family system with major communication patterns and operant in roles of Distracter, Placator and Blamer, respectively. The major archetypal theme was union or marriage and was presented in image form as seen in B's paintings, specifically the piece he was working on as he died and in the relationship that B and W had with each other. As both B and W were artists, their professional and personal life were both intertwined in a mutually satisfying life. Both had served as creative inspiration for the other and had many joint artistic projects completed as well as individual professional status. This relationship was a second marriage for both and appeared to have a special, nurturing characteristic that flowed back and forth from one another. It appeared that their shared artistic work was their child, a fruit of their union.

B and W were both highly spiritual people and expressed their spirituality in both their art and private pursuit of esoteric experiences. W related their long involvement with a "spiritual guide" that had come to B first in a dream and later in waking "visions" and who was a guide for B's spiritual growth and experiences, stimulated more heightened creativity and was also a healer by showing him the right way.

W was in the service of a denial function about B's
dying and both blamed and nurtured him in his illness. It is not known if they ever talked together about his dying, for all their emphasis was on positive thoughts and natural treatments that would cure him. W had a strong belief that the inner condition of a person would prevent any physical destruction or decay. She frequently referred in a troubled way to the ascendency of spiritual things over the body, and indicated that matter or body didn’t really count as much as spirit. Her communication pattern was almost always in the symbolic mode and it was difficult to understand anything concrete about the situation with her. W was visibly strained and intent on protecting both B and herself from the disaster that threatened them. Not once throughout the sessions did she verbally communicate that she knew or felt the seriousness of B's illness and the condition he was in. However, all non-verbal expressions indicated her awareness on an intuitive level and that she was frightened, helpless and lost. A sense of betrayal was indicated by her saying B could get better if he wanted to and she may have viewed his deterioration as rejection. W's view of B was an exalted one indicated by her referring to his accomplishments, personality and spiritual resources.

B also appeared to be as greatly involved with W as she was with him. His eyes followed her wherever she went, as though he had a self-possessed manner he always deferred to
her desires or feelings. He was sensitive and perceptive in his relationship to W and although he began to be in great pain, he tried to go along with W's wishes about the way he was treated.

As his pain grew unbearable and B could no longer contain his groans and moans, W more vigorously denied B's worsening condition. She used vitamins, food, treatments and meditation to prevent what she didn't want to happen and might have continued to the end if she hadn't been told to stop. W told no friends or family that he was dying, nor did she admit it herself. B lingered for many days longer than it seemed medically possible. He appeared to try to communicate with W but could not speak long or clearly because of weakness. W talked to him in spiritual terms and told specially selected friends that with prayer even now B could be cured.

It appeared that B was concerned for W and was acutely aware that he was dying. He did not communicate that to her. At no time did he break into their established communication pattern no matter how critical his needs may have been.

W, therefore, continued to distract herself from the dying process with emphasis on everything else but reality. The worse B became, the more symbolic and removed became W's communication. W began to baby B and to direct people's attention to the mother child image in his
unfinished painting. W, too, appeared to hear her symbolic communication and looked as if he was protecting her. Their union and the threat of terrible separation intensified in the last session.

The major therapeutic concern of this case was to enable W to use the blaming communication pattern in its positive way and to speak to the image of him as Hero in order for her to release B and herself from the great pain, guilt, and loneliness of the separation.

By using the metaphor of an esoteric spiritual marriage, therapy was undertaken in an attempt to have W begin to relate to the reality of the dying process in front of her. As recorded, W finally finished her business with B when the therapist adopted the function of spiritual guide. It was in those last moments of B's life that their business was dramatically completed and the image of a finished marriage released into the possibility of new integration and a future for W.

Dominant Archetypal Theme: The Child

P Family
Sex: female
Age: 44
Diagnosis: Cancer of lung, trachea
Length of care: one and one half month
Education: high school
**"W" FAMILY CHART**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>IMAGES</th>
<th>PATTERNS</th>
<th>ROLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation</td>
<td>Terrible mother</td>
<td>Denial, anger</td>
<td>Blamer</td>
</tr>
<tr>
<td>Struggle</td>
<td>Clinging tree</td>
<td>Repression,</td>
<td>Computer</td>
</tr>
<tr>
<td>Change, growth</td>
<td>The Child</td>
<td>Insight cooperation</td>
<td>Distracter (Congruent)</td>
</tr>
<tr>
<td>Union, fusion</td>
<td>Mother, mystical marriage</td>
<td>Nurturance, comfort</td>
<td>Placator (Cooperative)</td>
</tr>
</tbody>
</table>

The chart illustrates archetypal themes, images, patterns, and roles in a familial context.
Occupation: housewife

Marital status: married

Religion: none known

Husband: 45
  Occupation: blue collar
  Education: high school
  Religion: none

Age of family: 17 years

Family structure: closed system, nuclear
  child from former marriage not connected to family

Recent losses: none

Family members: husband, wife, step-father, mother, sister

Family present at intake: husband, mother, step-father, cousin

Role code:  
  Y = dying person - wife
  H = husband
  M = mother
  C = cousin*
  S = sister*
  F = step-father*

Role Communication, Archetype:

H = Placator, nurturing mother
Y = Identified Patient/ Distracter Child
M = Distracter, Decay
C = Blamer
S = Distracter
T = Placator

Role symbol connection-map:

Y to H = wife to husband as Distracter
Y to M = daughter to mother as Distracter
H to Y = husband to wife as Placator
H to M = husband to mother as Placator
M to Y = mother to daughter as Placator
M to H = mother to husband as Placator

* none means no significant observable connections
Y had fought her illness with radiation and chemotherapy treatments for seven months before the first intake visit was taken. The doctors told family there was nothing more to be done and the family was in stunned condition upon first meeting.

Therapeutic focus: denial, fear, hope, anger, sorrow:

Distractor

First visit: Y was in hospital bed in family room-kitchen area. House was clean, airy and full of arts-craft items made by Y. Family present on first visit were Y's mother from out of state, Y's stepfather, sister and husband (L) and his cousin.

Therapist sat with Y and husband and realized that Y hadn't been told of the terminal diagnosis. Therapist asked what she knew of her illness and she said it was cancer but that she was being treated for it. The worst thing for her she said were the results of radiation (she didn't add more explanation) and that she was weak and had to stay in bed or get around in a wheel chair. Y said she spends most of her time watching TV or making craft items. Y appeared depressed and somewhat frightened but did not speak of her feelings. When asked what had been happening lately she looked to her husband for him to answer.

Husband said she was taken ill suddenly and that they thought she could get better if she wanted to and took good care of herself. They practiced a sporatic, positive
attitude method of concentrating on her getting better. Therapist recommended they continue approach and asked what will happen for them if that may not work. Husband didn't answer by Y said that she will just get worse, she guessed. That made her angry and she didn't want to talk. Said she deeded her rest. Therapist said she saw she was angry about the thought of possibly not recovering and said that they could talk about that some other time. Husband was solicitous and babied her, covered her and tucked her in. Therapist asked if it was all right to come back and talk with them when they had more time and privacy. Y asked about what. Therapist replied about whatever was on your mind or made you have certain feelings. Y said yes.

Husband needed to talk and followed the therapist to door. Mother thanked therapist for coming and wanted to speak with her. Others in room wanted to know what the therapist and organization could do here, and information was given. Especially interested is husband's cousin who's eyes filled with tears easily and who shook her head when Y's illness was mentioned. Mother appeared tight lipped and avoiding cousin's reactions.

Y called for mother and mother went to her.

Husband walked therapist to talk outside and urged therapist to return, that there was a lot to talk about.

Therapeutic focus: Bargaining, purpose, determination;

Distracter, Time, Labrinth
Second visit: The theme of the second visit was set for the rest of the time with Y. She was helped into her wheelchair and took the therapist into the spare room to show her the county fair awards for her crafts. Y had a grown son from former marriage but has no contact or relationship with him. These hobbies filled her time. She especially liked doing things for Christmas. She was proud and insistant about her work and had planned to do an elaborate quilt of much design and intricacy. She went through a lot of trouble to find the picture and got angry when she could not find it. When she did find it she watched for therapist's reaction to what she wanted to do. Therapist said it looked like a lot of work and that it would take a long time. Y said that it may take at least half a year and that she would finish it.

Therapeutic focus: anger, guilt, desperation; The Child, Terrible Mother, Witch

Third visit: Talk centered around Y's anger and frustration at illness. Underlying cause is her relationship to husband. Husband is good looking and virile man - she said this illness is not good for him. She worried about "about his needs". Therapist asked about their sex life at this time. Question opened up the central conflict of her dying process. Y hesitantly began her story and related it with bitterness and frustration. She did not look at her husband until she was through. He remained quiet. She said
that for all but the last ten months of their marriage she had withheld herself from him sexually. She had a "crazy, romantic idea" about a childhood boyfriend and always wondered about him. Finally, she temporarily separated from her husband and sought out the old boyfriend and was greatly disappointed, but it freed her up. She said she now realizes how unfair it was to her husband and how much he loved her. For several months she had given herself to her husband and sex was good. Then she got sick, and soon that was taken away from her. This was her bitterness.

Therapist asked what was. Y said she began to dry up and intercourse was painful. She "began to shrink" and attributed it to effects of radiation on her throat. Said radiation was effecting her, making her worse.

Husband began to talk, clarifying some of her story. Said he always loved her and it was hard to live that way. He had his needs, he said. During their brief separation he had sex with another woman. Therapist asked him if he felt angry about living that way. He said "a little." He wished she could "be with him now" but "understands what she is going through." He "doesn't want to hurt her." He repeated that several times. Some indication here that H took care of those needs and that Y feared it now, when she needed him.

Therapist suggested that other ways of sexual satisfaction are possible. Y had distasteful reaction to the
thought. Wanted to "do it the right way." Complained that she "is like a little girl down there." Y felt unlovely, useless and not like a woman at all. She is aware, she said, of the contrast between her husband and herself. She was bitter and stubborn about wanting things to go her way about sex and her illness now.

H appeared grateful to talk about this problem. Said it was the worst thing about the illness. They were going to try everything to get her well. His attentive to Y and patient and also exhausted. Y frowned a lot, and avoided talking more about it.

Therapist suggested they touch each other in a caring way frequently in order to improve her "nerves". Suggested they talk about their feelings when they felt them, and to share them only when others were not around. Therapist was aware of mother's influence on Y which appeared to make Y more childish.

Therapeutic focus: anxiety, weakness, anger, avoidance;

Time
Fourth visit: Y weaker, had difficulty breathing. Needed relaxation and cleansing breath techniques. Used her oxygen with difficulty. Much time encouraging her to relax. Y says she "thinks too much", couldn't sleep and had bad dreams she cannot describe. Did not ssay about what she thought. Question was followed by an increased difficulty in breathing. Mother was anxious, hovering and
fluttery around her every need. Cousin was in living room. Wanted to know if she "had much time left", and didn't think anyone was telling her. Said she was sorry for H who was having to put up with so much and indicates the mother.

Therapist later talked to mother who sat on blanket outside. Mother seemed to want therapist to go away. Therapist offered that mother must be saddened by her daughter's illness. Mother starts to cry and said she didn't want to talk. Therapist said she saw her distress and would go away with the hope she could share these sad feelings with Y. Mother appears angry at the suggestion.

Therapeutic focus: weakness, bargaining, guilt; Union, Storehouse in Sky

Fifth visit: Y weaker, pale, often cold. Talked with difficulty now of what heaven might be. Said she had been to a faith healer. Therapist asks her what kind of things she brought away from that. Said she thought that the prayers didn't work. Wanted to try again. Mother urged her to, she said. Y said her throat hurt when she talked too much. Wanted to sleep. Still felt guilty she said about H about not being a wife to him. Therapist asked if she had talked about her feelings and the illness. Y said no, said she was going to buy the yarn for the blanket. Had the picture near her bed. Said it would be the best thing she's ever done. Repeated she was tired and wanted to sleep.
Therapeutic focus: anxiety, fear; Labrinth

Sixth visit: Therapist responded to H's call. Y is not eating, drinking. Wanted faith healer to come back. H will try anything. "It's happening too fast. She will die if she doesn't eat." H seemed confused, desperate. Mother, Y's sister there, terse, anxious and avoided talking to therapist. They seem strained and spent much time cleaning house or sitting by Y's bed. Y didn't want to talk. Said she must get the yarn.

Therapeutic focus: finishing business: Labyrinth,

Distraction

Seventh visit: Y wheeled from car to house laden with bag of yarn. Family took her out and Y chose yarn colors. Y intended to start blanket. Spent much time silently arranging and cutting colors of yarn. Her absorption in the task was intense. She was tired from the excursion, weak, pale. Didn't want to use her voice. H seemed tired but relieved to find her interest up again.

Therapeutic focus: grief, alienation, finished business: Integration

Eighth visit: Brief call. Y worked on quilt between bouts of exhaustion. Mother and father-in-law were present. H said they had shared some tears together. H is exhausted. Therapist encourages H to work on tapestry with Y. H was as proud of her accomplishments as she. He could help her with the arrangement of it. H is relieved to do something
with her. Said to therapist Y was a "little jealous of him taking to therapist, but it was nothing serious." Therapist sat with Y and complimented Y for her courage to undertake such a task. Y, who rarely looks directly at therapist, did so now and thanked her for coming to see her. Everyone had been so nice she said of the team. "I talked to my mother," she said. "I told her how I felt about her." Said she wanted to have her ashes scattered at sea, when the time came. Y says she will finish the blanket, no matter how long it takes.

**Therapeutic focus:** rage, grief, denial, finished business:

**Integration**

Last visit: Two weeks without visit. Y was actually dying. Team was called to house. Arrived minutes after she died. Family cried and looked at her. H took her in his arms and shouted no several times and beat the bed. Mother ran off to another room choking and threw up. H told Y he loved her and covered her with the piece of quilt she had beside her bed.

**Evaluation**

The P family was a closed family system and within that system the predominant communication patterns, the Distracter, the Blamer and the Identified Patient were expressed not so much by one person in a specific role but by all of the family members at some level.
The major archetypal theme was the Child as small, vulnerable and needing of protection combined with the negative aspects of the victim or Identified Patient who controlled the situation with anger and some guilt. Y appeared to be an angry, petulant child woman and there was some dissonance in her declarations of wanting to make love to her husband, for she did not appear open and vulnerable to him, but as if she were emotionally protecting herself from him for some reason. His approaches to her, as observed and through conversation, had to be done according to her tolerances, likes and dislikes with little observable return on her part. It appeared that the mother greatly influenced Y and although she was perceived as a great help by both she reinforced Y's manner of having things dominated by her. In this respect it appeared that Y was reacting to and capitalizing on a sense of harbored guilt in both the mother and the husband. Although stepfather and cousin were sometimes present, Y seemed to have no significant relationship to them and merely engaged in pleasant small talk. Y's sister was present and helpful in the same intense, wordless way the mother was - and was perceived to be part of the tightly knit group of mother and sister.

Both mother and sister were emotional but inarticulate throughout the dying process. Their quietness, almost like muteness, served to underscore the denial and ambivalence.
expressed. They spoke in basic ways about the physical care of Y and cried or got tense when Y's slowly deteriorating condition confronted them with the reality of her dying. Little interaction took place with the step-father. The few times he was present he seemed to be along to support the mother and he tried to stay out of the way. He was observed in conversation with H on occasion and appeared to feel useless and helpless in the situation.

Family conflict centered around H's sexual needs and Y's inability to satisfy them, which were clearly and easily understood without too much statement. Y frequently initiated talk about his "needs" and H often appeared frustrated. He remarked that she thought more about it than he did, and that all he was concerned for was her getting well.

She seemed to want to push the point and when attention was paid to themes and images as little girls and penetration she joined the subject with interest and energy.

The unstated conflict in Y was her need to allow her emotion to be touched in an intimate, vulnerable way, and she struggled for that as she died. Her struggle appeared related to her dying in as much as she fought off any advances to awareness of her situation and tried to act as if nothing was happening. When she had down and depressed times she was apathetic and indicated that she didn't like what was happening to her in a languishing way. Since her
strong preoccupation with sexual intercourse paralleled her worsening condition, it was perceived that she also related to her dying in the same way of either struggle or apathy and could not allow any other dynamic an expression that might allow her in integrate the real events into her wareness.

Her communication level was in the non-direct secondary mode and often appeared as double messages about herself. She appeared to feel caught and trapped both by her dying circumstances and her recent awareness about herself in relationship to her husband. It was as she said that just as she decided to "stay" with him it was taken away from her. This imminent separation caused them all to panic and to want to try the faith-healer.

The role of mother was functioned by H and all the members of the family. Y appeared to draw that out in people with the vulnerable childish ways she sometimes exhibited. Sometimes she would pout and once threw a tantrum about having to stay in bed and not getting better. Therapeutic intervention and support came in addressing the bitterness and helplessness of the situation and in trying to incorporate Y's new awareness of sex and love into the time she had with her husband.

The remarkable activity of guilt weaving or knitting brought with it the image of the Greek myth of Penelope who wove a large tapestry by day and unraveled it by night,
waiting for the return of her love, Ulysses, which took years. Around her house was the evidence of years of this type of activity and also suggested the labirynth or maze as an approach to "the Center" of the psyche.

It appeared possible that if Y were allowed to act out her wishes in the way of the quilt that it would satisfy a need in her to accomplish something that was meaningful and worthwhile to her. It was also an activity that she had to do alone and required much preparation. The act of linking things together as in weaving or knitting strongly suggests a disposition to bring parts of awareness into an integrated whole.

The Child image and the theme of intercourse appear bound together in a central theme of potential integration of conscious and unconscious activity, of potential future growth, fruitfulness and personal actualization. Such a theme and imagery carried an ambivalence within it in this situation because of the angry feelings of separation from actual intercourse and possibly Y's husband's affections when she was the most vulnerable.

H appeared aware of the delicate balance and unconsciously attempted to nurture her without giving up reminding her that he still had "needs" or that she was still not sufficient for him. H's nurturing appeared to be a way of vindicating his sexual behavior during their separation which later enabled him to grieve for Y without
waiting for the return of her love, Ulyssess, which took years. Around her house was the evidence of years of this type of activity and also suggested the labrinth or maze as an approach to "the Center" of the psyche.

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too much guilt.

When Y died she appeared to have let go of the "virginity" of the child long enough to attend to the business of saying feeling things to her mother and sister as a good-bye. It did not appear that she made direct communication to H about their relationship in the last days of her life, but it was observed that H was even more tender and nurturing to her emotional and physical needs and that she thanked him for everything.

Dominant Archetypal Theme: The Dance

E Family
Sex Female
Age 60
Diagnosis: Cancer of the ovary, metatasis to general abdomen
Length of care: five months
Education: high school
Occupation: housewife
Religion: none
Marital status: widowed
Deceased husband: Occupation: engineer
Religion: none
Age of family: approximately 27 years
Family structure: closed nuclear, grown children
Family members: three children, oldest from former marriage
**"P" Family Chart**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>IMAGES</th>
<th>PATTERNS</th>
<th>ROLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Separation'</td>
<td>Terrible mother</td>
<td>'Anger, denial'</td>
<td>Blamer</td>
</tr>
<tr>
<td>'Drowning'</td>
<td>Silence, victim</td>
<td>'Worthlessness'</td>
<td>Placator</td>
</tr>
<tr>
<td>'Formless'</td>
<td>Labrinth</td>
<td>'Denial'</td>
<td>Distracter</td>
</tr>
<tr>
<td>'Union, nurturance'</td>
<td>Great mother</td>
<td>'Comfort'</td>
<td>Placator (cooperate)</td>
</tr>
<tr>
<td>'Time'</td>
<td>Ritual, labrinth</td>
<td>'Awareness'</td>
<td>Identified patient (awareness)</td>
</tr>
</tbody>
</table>

**Themes**
- Separation
- Drowning
- Formless
- Union, nurturance
- Time

**Images**
- Terrible mother
- Silence, victim
- Labrinth
- Great mother
- Ritual, labrinth

**Communication Patterns**
- Anger, denial
- Worthlessness
- Denial
- Comfort
- Awareness
Recent losses: husband died three years prior, moved from home into trailer park one year prior.

Role code:
E = dying person
D = daughter, youngest
S₁ = son, oldest
S₂ = son, middle
H = deceased husband

Role symbol connections-map:
E to D = Mother to daughter as Placator
S₂ to E = Son to mother as Computer
S₂ to D = Son to sister as Blamer
D to S₁ = Daughter to brother as Distracter
D to E = Daughter to mother as Identified Patient
S₁ to E = Son, to mother as Distractor
D to S₂ = Daughter to brother as Identified Patient
S₂ to S₁ = Brother to brother - Balmer
E to S₂ = Mother to son as Placator
E to S₁ = Mother to son as Computer

Role Communication, Archetype:
E as Placator, Dancer Mother
D as Identified Patient - Victim
S₂ as Blamer - terrible mother
S₁ as Computer - Hero
E chose no active treatment to prolong her life. The first interview was long and was made two months after diagnosis and indicated that this decision was a source of mild conflict between her and her grown children. She stated they thought she was "giving-up" despite her feelings that she was "doing something for herself". She was clear in her statements about wanting to make the time good while she had it. She mentioned her dying outright only once in a manner that was efficient and quick and watched for a reaction. She stated she hoped it was fast. She had made arrangements for bills, possessions and cremation and burial already. She talked about her illness and what she knew about it and then stopped. She expressed a need for reassurance that she wouldn't suffer.

The physical indication of her illness was a large swelling of liquid in her abdomen. She joked that she looked pregnant and wondered what sex the child would be. She was ambulatory, appeared in good spirits and was guarded about showing emotion though she talked about herself. She talked about her husband, deceased three years earlier, and how her life had changed since that time from housewife to volunteer, as well as a sense of both lonli-
ness and release.

Discussed what practical thing could be done with her illness at home. She stayed in control, making tea, asking questions, asking this therapist to do things.

Offered a brief sketch of her past history, before she was married. Remembered herself as a dancer in her early years in travels to Europe. E lived alone, a middle son nearby, has one male friend near and a woman friend comes to see her often. E knew no one in trailer park. Trailer done in comfortable traditional style, a portrait of grandchild prominently displayed. E wore eye shadow and dressed in elegant night robe. Said she tried to keep things up around the small yard and interior, but it was difficult. E talked briefly about her volunteer work in hospital after husband died. Mentioned a daughter and expressed an unspecified concern for her. Therapist recommended keeping a log of dreams.

Therapeutic focus: alienation, distance, depression, restlessness; the Dance, the Mother, the Father, Hero, the Clock, Decay.

Second visit, three weeks later. Patient wondered where therapist was, is only person she can talk with. Spent time at family albums. Much focus on picture of her as young woman, as Dancer. Talk centered on her life with her mother and grandmother, first marriage and travels to Europe and WWI. Described pictures of second husband as
"too formal" not doing him justice. Described husband as strict, authoritarian man who treated her "like a queen". Discussion of pictures of children indicate oldest child of former marriage and daughter (born when E was in 40's) are favorite. Oldest child described as "free soul". Middle child described as being just like father. Said he is somewhat stuffy. Both father and son were engineers. Said daughter more like her - had to protect her from father's strictness.

Therapeutic Focus: separation, defensiveness, rejecting;

The Journey. Third visit. Therapist meets S1 and E is pleased with the visit. She was charming, seductive and deferred to son in general manner. S1 was well educated and aware of mother's condition. Appeared to be here to see what her condition was because of a long planned action he would be making in the next month. E appeared to be guarded about her reactions to him leaving - tension about the journey. Therapist asked S1 how he felt about leaving at this time. S1 responded he is hoping to do the right thing and can't be sure. E said not to dwell on her illness. Therapist asked E how she felt about him leaving and she didn't answer right away but then said it is best for everyone (meaning S1's daughter, who was to go with him as well).

Therapist talked with S1 privately and S1 said he didn't really have much feeling for the rest of the family
and didn't know his mother too much anymore because he left home as a teenager after trouble with the father. Asked therapist's opinion about how long it might be. Therapist gave no definite answer. S1 also said he didn't know his stepbrother or sister too well, and didn't really need to. Discussed daughter as youngest child but "wanted" even at such a late time in her life. Appeared to have conflict over the memory of raising her daughter. Daughter's child object of much concern. E was troubled when she spoke of her daughter but again was non-specific - alluding only to daughter's emotional problems.

E felt depressed this visit, said she wanted to die, felt useless, frustrated and angry about being ill. Wanted to know how long. Indicated thoughts of suicide. Had restless nights, can't sleep, wakens in deep night and that those are worst times. Only dreams are unremembered troubled ones. Joked about it being the end for her when she no longer can get her eyeshadow on. Encouraged her to do as much as she could in the time remaining her. She didn't want to impose. Talked about her letting people do things for her. E asked if therapist will meet her daughter. Informal arrangements made to meet middle son and daughter.

Therapeutic focus: anger, pain, Drowning.

Fourth visit. E needing more frequent hospital visits and is irritable, depressed, wants to know "how long?" and has
no interest in anything anymore. Said body fluids are "killing" her. Upset oldest son is going on vacation but refuses to tell him in order not to ruin his trip. Pain cocktail now irritating her. In some physical discomfort. Wants to make no decisions about discontinuing medication, saying something to son or daughter or doing anything at home. Asked again that I meet her daughter.

Therapeutic focus: anger, resentment; Computer.

Fifth visit. Met $S_2$ and male friend in home. Son tried to please her, very attentive. Had come every day after work, did shopping for her. Man friend cared much for her and worried, said aside to therapist that he didn't know what to do. Son's helpful manner was awkward and stiff. He appeared nervous in discussion with all of them about what kind of things E might do and enjoy now. $S_2$ talked to therapist alone, said mother's dying "is best thing she can do", that she was lost and out of order with the volunteer work she was doing since father died, "she didn't seem to know what to do with herself."

Therapeutic focus: relief, control; Water, Strone, Dance, The Father.

Sixth visit. E had spent much of her feeling good time going out to eat seafood with male friend or son's family. She had chosen to indulge in an oyster splurge and has been taken several times to places where raw oysters are served as appetizers. She joked about the aphrodesiac that
they are, said she is becoming "fertile". Therapist said oysters were a strange food. E joked that she hadn't found a pearl in one yet but was going to keep trying. Mood was better than several previous visits. Oyster fetish and the ocean remained a theme in several remaining visits. She displayed her husband's hand painted soldiers and elaborate ships saying that it took great control that she never had. E looked for and finds a carefully saved dancing costume from her early days and showed the picture of what she looked like in it. The contrast between husband and that part of her was even more pronounced.

**Therapeutic focus:** Denial, avoidance, sorrow, finished business; Time, the Child, Placator.

**Seventh visit:** Daughter's visit coincided with Therapist's. Interaction between mother and daughter shows how much E was affected by moods of young daughter and daughter by the way mother feels. Daughter highly nervous, troubled and defensive about herself and tried to maintain image of "cool" person. E waited for daughter to tell about herself saying that this therapist can be trusted. E seemed satisfied that daughter see about her situation and during the exchange said little. Therapist's noticed E's tears at one point. Asked E about them. E is embarrassed, said she wants daughter to know she loves her no matter what. Daughter awkward with information. Said she loves her in
an awkward manner. This was first time, E said, that daughter has said that out loud, even though she always knew it. E stated that now she thinks daughter will be better off when she dies and doesn't have mother to run to. E was moved, some tears. When therapist started to leave daughter asked how long when out of earshot of mother. Said she can't get up to see mother often. Daughter was burdened by many problems, said she was wasting her life.

**Therapeutic focus:** weakness, decay, regret, worry, Decay, Victim, Placator, Great Mother, Sees her Corpse.

Succeeding visits. Centered around E increasing weakness and symptoms and talk of her daughter. Her abdomen began to grow to nine months pregnancy size as she described it. Sh wanted assurance that she would not die ugly and in bad taste, as she had seen her husband die. Wanted no one around her when she died. Discussed with her the possibility that it might be ok that her family were present. She stipulated it would be ok only if she were not repulsive. She frequently mentioned her youth - talked of what it was like to dance, and said how different the last three years of her life had been as single, a volunteer. She considered herself so protected, sheltered by her mother and husband and this was the only time in her life she'd done something on her own beside dancing for fun. E said she began to see life directly for the first time.
She did not regret her marriage, she added, and hoped to rejoin her husband in death in heaven.

Her repeated concern was for her daughter and daughter's child who was to be adopted by middle son. Such a move greatly disturbed E and she worried about daughter's loss of feeling. E hoped to live long enough to see her through the trouble she was in. She felt responsible for her as if it were all her fault for raising her wrong by giving in too much and by protecting her. Worried that daughter would further hurt herself after she died. She hoped that the therapist would be in touch with daughter after her death.

E was very conscious of her children's reaction to her dying. Her oldest son she felt was avoiding her and was uncaring and thought that too was because of the way she raised him and appeared resigned to it. She knew her middle son hated hospitals and illness and worried about making him feel obliged. She wanted to oblige no one to give attention to her. Therapist said she was a "real lady" in the old manner and saw that it pleased E greatly.

E's only regrets were that she had been stronger in raising her daughter and that she had done more things with her life. E said she felt she was looking at life through everyone else's eyes. Said she saw herself in her dead husband and that she hasn't been the same since he died. Had a male friend that really liked her but that son and
daughter didn't approve of so didn't make much of it. But he died too in the past year, feels it was a sign to her.

Therapeutic focus: finished business, sorrow; Time.

Last visit: E spent the last two weeks of her life in the hospital where family and therapist visited. E was weak and responded to little. On the occasion that all the family gathered by her bed she literally rose to the occasion by sitting up and responding to each person as they came in, then would lie back. If someone talked to her, her expression became alive and animated in response to that person. Her energy outputs were marked and visible. She spent over an hour alone with her daughter sitting up and talking with her. She spoke alone with each child. After they left she relapsed and was almost unresponsive until her death four days later.

Only once she looked up out of her semi-comatose condition and asked this therapist how much more time it would take. Not getting an answer, and seeing the therapist's tears, she asked what was wrong. Therapist said she was sad to lose her. E said not to cry, that she didn't like tears. Therapist said that she knew that but that she had to catch up to where E was. E smiled. She spoke a few minutes later saying that she loved the therapist. Therapist said she would always remember her. E appeared satisfied.

E died with a smile on her lips several days later.
while being turned by nurse. Sometime before the day she died she remarked to a therapist "You know, dying isn't all it's cracked up to be."

**Evaluation**

E family was a closed family system with major communication patterns and roles operant in form of son as Computer, E as Placator and daughter as Identified Patient. (The deceased father was present by way of much conversation about him and his behavior and can be considered present and influential as the Blamer.)

The major archetypal image of the E family was the Dance as seen in E's focus on dress, memory and pictures of that part of herself. The Image of Dance was therapeutically associated to the process of initiation in E's life through death. E admitted to marked changes in her life that led her from one condition to another as in her Dancing to her marriage and her husband's death to beginning to live life as "her own person" after her husband's death.

E was the central connection for the family through which nurturance and affection were allowed. E was the "star" in the family and though E's dying was the focus of therapy the daughter constellated the opposite function of the "star" mother as becoming the identified patient. As the identified patient she carried the unconsciously
projected conflict in the relationship between E and H as well as the known internal conflict of spontenaity and control in E.

The power or energy of the family was thus centered around the mother-daughter relationship. E's regrets at the ways she raised her children and what she allowed appeared to be dessonant to her expectation and sentiments about herself as a "lady". With such a conflict existing both in E and in the family life E felt helpless and tried to compromise the unstated stresses by agreement on not rocking the boat. Her position in the family was opposite of the father and that in itself caused more conflict in the children.

As E was dying she "choreographed" the ways in which people should relate to her by telling each one that came into her process something about herself that affected them directly. It is important to note that she did not tell any of her children or firends everything about herself but gave selected information that appeared to match what she thought they could handle. She reserved the less "lady-like" parts of herself for the therapist, things as depression, weariness, irritation, restlessness and anger. She constructively used the dying process to her own ends with other people as seen in the insight that her "daughter would be better off without a mother to protect her." In the context of such use she performed a "dance" that others
could come in and out of as they chose if they followed the dance "step" or pattern laid out by the central character, the dying person E. E initiated each member of her family and two friends into allowing change to be part of their lives as she had come to realize was important to herself in the last three years of her life.

Such a change was that she was leaving them on their own, without any parent to refer to. She became increasingly articulate about her being the one they could talk to about their feelings and began to realize that they needed to find the feelings in themselves. The image that came up for E at this time was not only the Dance but the image of the storehouse in the sky or heaven in which she believed in an unspecific way as indicated that she would "go to join" her husband who was still watching her." When asked where he was she indicated that it was in a heaven of some kind. E often looked upwards when she spoke about this.

E also felt it was ironic that she should learn things about living just before and during her dying. Her perceived irony correlates with the initiation processes of the Dance archetype which indicate transition and passage from one psychic state to another.

The communication patterns were solidly fixed and allowed for no change. E spoke either bluntly and directly or in symbolic metaphor about herself. Either appeared to be an unreconcilable communication pattern that allowed for
little alteration. Her directness about her dying appeared to be a defense against the feeling part of the losses she was experiencing, and when E appeared to have great emotion about dying she would not (could not?) speak in anything but symbolic references. E was often aware of the symbolic references she made and at those times looked to the therapist to see if she was picking up on the hidden meaning of her communications. Such a dichotomy in ways of communication indicated the internal conflict and contained. Such conflict was also reflected and carried out in the communication roles and patterns of the family members.

The deceased husband was perceived by the family as controlled, severe, rational and predictable. E said he was a good man who brought order into her life. S2 said his father was properly strict and someone to look up to, and daughter perceived him as cold, blaming and rigid. S1 and no warm feelings for father and perceived him as the reason he left home. All of the family continued to refer to the deceased father as they interacted in recollection and behavior throughout E's dying process. The internal conflict between E's spontaneity and H's control was furthered by E's choice to take no treatment. S1, already emotionally separate from family, appeared almost non-committal, saying what E did with herself was her choice. S2 appeared to have constellated the position of H in the service of Blame by His initial judging posture of E's
decision as if she were "giving up". Later, his acceptance of her dying as "the best thing she ever did" was also done in a Blaming manner for S2 added that she was at "loose ends" of her life after his father died thereby inferring that the activities and relationships that E cherished were perceived to be worthless and deviant from what S2 perceived was her former role as it related to the father.

D perceived E only in terms of E's health and ability to assist and relate to D. D stated it was difficult to think that she was really dying because E "looked so good" when she saw her and said she thought her mother would always be there. D perceived herself as guilty and worthless, and helplessly caught in a web of problems. Her child was given over to adoption to S2 and that caused great conflict and anguish to E. D denied any feelings once the adoption was over and such denial furthered E's suffering about D's emotional condition.

In fact, the therapist perceived D to be in a borderline situation caused by great internal shame, guilt and suffering with tremendously inferior feelings. D could not allow herself feelings in this condition as it would seriously threaten her ego functions with collapse. Therefore, D appeared automatic, nervous, brittle and despairing.

The family conflict then revolved around D's precarious mental condition and the imminent loss of her mother. S2
felt charged, and in fact, was given the responsibility by E, with the welfare of D after E died. S2 was not grateful for this responsibility as he felt D wouldn't "shape up" and was too emotional. S1 likened D to the mother in that respect indicating again more blaming of E.

D's relationship to S1 was not favorable for D felt S1 was too much like her father and that she couldn't handle her feelings.

The dying-transforming family's conflicts, therefore, had equal possibilities of annihilation and liberation as a mode of relationship to the dying process. The therapeutic intention was to facilitate absorption of both possibilities into the awareness of the family members according to the themes they held by the use of the images that arose out of them and by doing so would allow them the possibility of a more aware choice for their continuing behavior as a transformed family. Their annihilator themes were many: a struggle to allow for emotion, the drowning in too much sweetness to keep things as they were, and the further separation and distancing of their relationships through death and it was possible that they could have seen death as an affirmation of negative conditions. However, the E family had at the same time liberatory themes and images that indicated the potential for initiation into new forms of communicating and being, a potential for change and growth as a family and a sense of wholeness through more
constructive uses of time. Since both themes emerged in image form out of the dying process, the therapeutic intervention was directed to the negative images and themes through the use of the positive imaging the family had within them.

Literal dialogue in a freely associative mode was directed to themes such as journeys, daughters and struggles. Active imagination techniques were applied to the images of Dance, clocks, oysters and oceans, pearls, father, hero, and child which produced the desired affect of reinforcing the healing imaging within the family as they became aware of those inner images and the way they related to them.

Much needed unfinished work about the father's death appeared to take place in the hospital as E was dying. Discussion about the father indicated a strong need to express feelings still affecting the family about the way he died and their unexpressed emotion for him. Their expressed repulsion to hospitals was related to the time and manner of the father's death. The family's presence and communication with E and one another appeared to have a healing and integrating effect on the wounds of the former experience with the father.

When E died, the family had begun new, tentative manners of contact and communication with each other. All of them, even S1, became aware of the need to express
feelings to one another about their lives as a "family" and such an awareness, after avoiding it for their previous years together, served as an initiation into the possibility of a new, changed and more unified family.

Addenda: The therapeutic process with E initiated an awareness of the Dance archetype of initiation or passage as an archetypal theme that may be also true of most dying-transforming families, and can be explained in the following manner: The dying person dies in a manner that parallels the patterns of his/her life. At some point in life the individual may choose to accept death and begins to "dance" a new "dance step" that is woven out of the fabric of his/her life. The family, friends and all others in contact with the dying person come in and out of the dance at will and learn the new dance step as they dance with the lead dancer. Such a dance can be considered the "Dance of Sorrow" (Hochberg, 1978).

Dominant Archetypal Theme: The Scapegoat

G Family
Sex: Female
Age: 65
Diagnosis: Cancer of the pancreas, possible metatasis
Length of care: Three months
Education: Highschool
Occupation: Housewife
**ARCHETYPAL THEMES**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>IMAGES</th>
<th>COMMUNICATION PATTERNS</th>
<th>COMMUNICATION ROLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Struggle</td>
<td>Clock, water, bad dreams</td>
<td>Cool, emotionless</td>
<td>Blamer</td>
</tr>
<tr>
<td>Drowning</td>
<td>Water, victim</td>
<td>Agreeing</td>
<td></td>
</tr>
<tr>
<td>Initiation</td>
<td>Dance</td>
<td>Insight, transformation</td>
<td>Blamer (responsibility)</td>
</tr>
<tr>
<td>Change, growth</td>
<td>The child, indestructible stone</td>
<td>Peace, purpose</td>
<td>Distracter (congruence)</td>
</tr>
<tr>
<td>Time</td>
<td>Clock</td>
<td>Wholeleness</td>
<td>Computer (ordering)</td>
</tr>
</tbody>
</table>
Religion: Jewish
Marital Status: Widowed
Spouse: Deceased within the year
Occupation: self-employed
Religion: Jewish
Age of Family: 48 years
Family Structure: Closed, extended
Recent Losses: Husband's death that same year.
Moved from her home, and disassociation from her son.
Family present at intake: Daughter
Role Code:
H = Dying person, mother
S = Sister, daughter
B = Brother, son
Role symbol connections-map:
H to B = Mother to son as Blamer
H to S = Mother to daughter as Placator
S to B = Sister to brother as Blamer
S to M = Sister to mother as Placator
B to M = Son to mother as Identified Patient
B to S = Brother to sister as Blamer
Role Communication, Archetype:
H as Blamer - Terrible Mother
S as Blamer - Hero (negative)
B as Identified Patient, Placator - Victim, Scapegoat

The Scapegoat
H had been in the hospital for several months prior to the intake visit in her daughter's home. H knew of the seriousness of her illness and of the prognosis.

Therapeutic Focus: Grief, hysteria; Placator
First visit: H was admitted to the program through her
son, a month prior to her in-person intake. Son, B, was anxious to give her the best care, and cried over the phone: "All this is too much to take." Father had died that year on his birthday and "now this." Declared his love for his parents. "They are the world to me." He wanted to take care of his mother.

**Therapeutic Focus:** Anxiety, anger, hysteria; Terrible Mother, Witch.

First visit with Son and his wife: Discussed the possibility of H staying with him. Asked what he should say to her when he visited her in the hospital. Therapist suggested he say whatever was appropriate about his feelings at the moment, and share with his mother his concern for her.

B said there was the possibility of hard feelings between himself and his sister. Said sister was "a witch" and might fight for the care of their mother. He didn't want to fight, but she hated him. He "only wanted to do what was best." His wife attested to the long sibling feud. The wife was quiet, docile and nervous. B swung from calm to rational to simpering and distraught. He cried about his "beloved father" who, he says, "may have been cruel on occasion, but I would belly up and forgive him because he was so good." B agreed to let Mother decide and to let her live the way she wanted. B stated that his sister wanted all the family money and might bend his
mother's ear away from him. Therapist said that they might cross those bridges when they came to them.

**Therapeutic Focus:** Obsession, fawning, anger, rejection; Terrible Mother, Placator.

Second visit: B distraught about results of visit. Said mother turned him off when he cried and told her how much he loved her and would miss her. Said she didn't want to hear him and was angry that sister's place may be chosen where mother would die. He wanted to put her up in his room, light candles for her, wait on her. Said he must be good to her the way she had been. Therapist asked what kinds of things were good about mother. B said she is a "saint." Said sister always tried to get between him and his parents and had usually had her way. Told of the kind of things which were her fault. Said that he had followed therapist's suggestion and had told his mother about the past angry feelings. It had made her worse and she turned him away. B felt that the therapist had given bad advice. He asked what was wrong and how could he change it (in a whining manner).

**Therapeutic Focus:** Division; Blamer.

Third visit: Therapist had a call from the sister about the care of mother. Said she could take better care of her if she came to her house and referred to the bad feeling between her brother and herself. Said he was a "crazy man," and didn't want to involve him.
Therapist conferred with B and suggested that he direct all feelings to the appropriate sources. Therapist stated she would not be the messenger, and the greatest concern was for the welfare of the patient and her family.

**Therapeutic Focus:** Reassurance, rejection; Blamer.

Fourth visit: Intake with daughter and mother at daughter's home. Not much care needed. They will call if they need us. Asked for information. Assurance given that help is there when needed. Does not want to see brother.

**Therapeutic Focus:** Helplessness, rejection, insight anger; Terrible Mother.

Fifth visit: After almost one month later, daughter began to make the statement that they needed some help because of the mother's discomfort. A brief contact had been made since the last visit: H had been well and able to go out to lunch and shop. S now wanted help to keep her mother.

B had been excluded from sister-mother situation. Intermittent visits with him indicate a long family development of this excluded feeling. Related things he felt were unfair and one-sided in favor of sister that angered and hurt him. Asked what he did with angry feelings, he replied that he wasn't angry with parents and that he would never show them anger. This exploration of his feelings made him tear up. Therapist asked about the tears and B said that he could never show anger because they would withdraw from him.
B said that a lot of the mother's distance from him is because he is "a Jew who believes in Christ." Mother doesn't understand him or it. B expressed frustration at Mother being at S's house. B's wife said she was relieved that her mother-in-law was not staying with them, because it would have been a major adjustment in their lives. They were suffering financial stress. B grieved that he would not get what "was promised me", if S has her way with H. Said his father and mother had urged him to move to this State in the promise of joint business ventures. He felt betrayed, outraged, helpless.

B wanted to be kept informed about mother and only wanted to know if she was well and comfortable.

S does not ask about B except to offer to leave the house if he needs to see H. Could not be in the same house with him.

Contact with the family was through the nurse for several following visits. Then nurse reports a great restlessness in H which was not accountable.

**Therapeutic Focus:** Restlessness, anger, guilt, anxiety; Decay, Time.

Sixth visit: S, her husband, son and daughter and H present at the beginning of the visit. All are polite, busy and then leave. S and H sat in the comfortable but nondescript environment of the family room. H was looking well, but complained of restlessness, of boredom. She had
vague pains all over.

S asked if she should leave. Therapist said she might want to stay. Talk of illness referred back to husband. She indicated he had died quickly. Therapist suggested that it must be lonely and sad for her to be without him. H repeated what the Therapist said. Therapist asked about their life together. H said it was long, they never fought, that all in all he had had a good life. S sat watching with interest. Therapist asked about the children and how she came to be here with her daughter. S answered that it was the most comfortable place for her. In this session, S indicated that she wanted this time with her mother. Said her father was not easy to live with.

H talked about her husband's death with no feeling. S asked mother if the years were good with Dad. H answered noncommittally.

Therapist asked H how she was making use of her time. H answered about seemingly trivial concerns such as feeding the dog, walking, going out for a drive.

When she asked about the son, H shrugged and said that it's no use. All in all, H wanted nothing to do with him. H felt B is troubled, and said that he upset her with his crying and saying things always dredging up the past.

H responded to therapist's question about how B might have feelings he needed to share, by saying "she knows it is her fault, that maybe she should have raised him
better." She had "given him all kinds of gifts, money' and "did the best she could." H is distraught with these thoughts and closed her eyes. She complained of vague stomach pains. Therapist asked H if she could forget what she "should" have done and do what she feels like doing now with her son.

H turned to S for direction. Said she should do what she wanted. S said B was never satisfied. H said that "it was all my fault" and that she should have done more. Therapist responded that H might be feeling guilty about B. H repeated the word and said that she did. From that point on, H closed her eyes and slightly averted her face. She didn't talk much and complained about too many questions. H laid back on the couch. Small talk occurs with S who appeared nervous at the end of the session.

Therapeutic Focus: Pain: Suffering

Seventh Visit: H had bouts of not feeling well with pain and then clear moments. She was restless and ambulatory. Time was spent mostly with S, listening to her reactions to last visit. S said H had never admitted to guilt before. S was amazed at how direct H had been during that previous conversation. S was shaken by her mother's admission. She said that it was a first, but that H's reaction with the closed eyes afterwards was typical of how she really was.

S was agitated about H's silence about her father's
death. S was troubled by the thought that maybe H hadn't loved her father all those years. Therapist asked her that if she knew, would it change anything for her. S said no, that she would do what she could for mother. S was still wondering about mother not grieving about father as therapist leaves.

**Therapeutic Focus:** Pain, anxiety, rejection; Chaos, Power

Following visits made by the nurse: H needed heavy medication. B had contacted her by phone and wanted to see her. H is upset with him. B appeared to have disturbed the entire S family with his contact.

Therapist worked with S about brother. S wanted B to stay away from them all, she said. Said H refused to see him and that B dried and acted like a baby.

H stipulated that she did not want to be "bothered" by B and arranged through legal channels to keep him away. Issues of legacy, promised money and broken promises surfaced and became a power struggle for H's attention to B. An ugly fight left both families bitter and raging.

The team was adversely affected by the war between the two families and pulled back temporarily, except for H's nursing care. Both factions demanded the therapist be only on their side, and worried that information was being given about themselves to B.

**Therapeutic Focus:** Powerlessness, guilt, anger; Death, Time
Succeeding visits are primarily to H for S was defensive and businesslike about herself. H had periodic attacks of pacing, agitation, loss of memory, irrational talk and uncontrolled body movements. During these periods, she asked S to "kill" her and "get it over with." S felt mother was suicidal and wanted to do something to calm her; she was agitated and panicked about her mother's behavior.

H asked "how can she know she is dying?" and complained "Why am I not dying?" "Why doesn't God take me now?" H appeared to feel she was being punished.

Therapist gave permission to H to live and not die on what she thought was a schedule from the doctor's original prognosis of 6 months. Throughout this period H and S reflected each other's moods and reacted to one another as in a mirror. Suggestions became fact to them, and they are easily influenced by questions and by what they perceive to be feelings in other people.

The team began to bear the burden of their rejections of B, and it became divisive to the team. Infrequent contact was made with B about his concerns for his mother. He was enraged that she would not see him and believed it was his sister's doings. B tried to commit suicide when he heard that the allotted income was to be cut off. Everything was handled by lawyers. H said she needed the money.

Therapeutic Focus: Turmoil, weariness, rejection, denial; Drowning, Devouring Mother.
The remaining period of the G family life was spent in turmoil and confusion. S was exhausted and strung out caring for her mother. She spent a long time wrestling with the question of allowing her brother to see H. She wondered if she was influencing H and felt guilty. Mother said news of B is "dumping on her."

H had extreme behavior swings between physical pain, disconnected talk and agitation to periods of quiet and ordinary talk. He seemed not to remember her pain, or what she said during the bad moments. Possible pain drug reaction investigated and the drugs were discontinued. Extremes of behavior continued. In quiet moments, H said S is "smothering me." S agreed and tried to get distance from the situation by arranging to be away from the house more often. Contact with B indicated that B believed sister and mother were "killing me." He said he would try to forgive and be "more Christian." Therapist suggested he dialogue with mother on paper and asked him what he will do with angry feelings. B responded that he will try to love more.

Therapeutic Focus: Chaos, dissolution, guilt; Time.

Serious questions were raised about H's behavior as a drug reaction or a psychotic episode. H appeared to respond when she wanted to. H was asked if she wanted to finish business with her son. "I don't ever want to see him again," she replied. H had a brief recovery and had made
plans to go to the hairdresser shortly before she died. S was confused and unsettled by such behavior. S quietly said she wished it were over. She would "never do something like this again" even though she loved her mother, she said.

H was suddenly confined to bed a week later. S stayed by her bedside. S was certain "Mother would die on Sunday. It was her favorite day, and it was ironic that it was also B's wife's birthday.

H died without reconciling with B or without further communication about herself. B heard about H's death the following day when a relative called to offer condolences.

Team nurse reported that B went to the front of the chapel and began to chant in Yiddish over the coffin, disrupting the rabbi speaking. The family left by the side door to avoid him. B screamed and cried as the procession left. He draped himself over the casket at the graveside and cried hysterically and periodically kissed the casket. As S and her family left, B shouted obscenities at them. No apparent resolution.

Evaluation

The "G" family system was a close done, and their dysfunctional communication patterns were firmly fixed and many.

The mother and father communicated generally both in a
Blaming mode with the mother also as a Distracter and the sister as a Computer. The son's communication pattern was primarily that of the Identified Patient/Placator from which the other patterns derived their raison d'être.

The major Archetypal image was the Scapegoat or Victim and the theme appeared to be dismemberment—devouring by the mother. It appeared that no one in the G family could nurture or nourish one another, and that such inability was borne out in the image of the Devouring Mother. This was the pattern throughout their lives. The issues were primarily parental love and the attention needs of the children. The issue became symbolized in terms of money or power (energy) given or an investment made to one or the other sibling. Conflict and Alienation were the underlying themes throughout the dying process.

There was a literal tug of war for the possession of the mother from the onset of contact. B displayed himself in an attention-getting manner by hysteria and morbid grief over the deceased father and the mother's prognosis during the same year.

B did everything to convince the therapist that H should stay with him, as if the power of this final choice lay with what he perceived was an outside authority. B's polarization of the feud between S and self indicated great anxiety about the projected maliciousness of his sister and her power to inflict harm to him.
B saw himself as loving and good, and a victim of inexplicable wrongs and bad feelings. B carried a burdened, inferior small and worthless attitude about himself in relationship to his family. S's attitude was calmer, but she was an insistent that she care for her mother and gave rational, practical reasons. S was in a better financial and environmental condition than was B and could carry out her desires. B and S contacted H under the therapist's suggestion so that H might make up her own mind. Both siblings tried to influence her. When H went to S's home, B was both upset and relieved. He did not admit to relief, however. B felt more closed out from H's attention and more in conflict with S. His fear that S would turn his mother away from him became true for him as he sent demanding and pleading messages to H for him to see her at S's house. Therapeutic intervention began to be divided between H and B and became strained. Therefore, since H was the primary object of care, referral was made so that B might seek alternate outside therapy. S was aware and satisfied with the possession of H. She attempted to give her "everything." She maintained that all was well, that she never had any anxious moments about H dying in her home, that everything was under control and would stay that way, if only B would remain out of the picture.

H appeared to be a nice old lady who complained about her problems of ill health and readjustment with a touch of
fatalistic humor. H avoided any subject that became too direct or probing about feelings. Her central mode of communication was secondary and double-messaged. She asked questions instead of making statements about what she was thinking. It was difficult to find a "she" in it, because she evaded and eclipsed herself with references to everyone else's behavior and expectations. H swayed easily with the color of any mood at all times and appeared to have her decisions made by those around her. H admitted only once to guilty feelings about her son's manner and feelings. Shortly after this she became ill and had what may have been a severe psychic reaction to such a disturbing admission. As the situation of rejection and blame became more critical, H became more and more ill. She had great losses of memory and could not be held accountable for her actions. The siblings increased their destructive behavior toward each other. B's attempted suicide may have been a grab for some control of the situation as well as to gain attention to himself. The many references to killing made by all members involved reiterates the mutilation and victim theme.

Both H and S behaved in the service of Denial by the communication patterns of Blaming and Computing. B carried the burden of their projections and rejection with the opposite display of extreme emotion and hysteria. B displaced anger to S and could not direct it to the mother
for fear of further retaliation and destruction.

Most of the dynamics in the G family appeared to be destructive and are negatively related to the dying process.

Any positive symbols or images might be found, if at all, in the newer relationship between mother and daughter as the daughter perceived herself as clearing up old debts.

H's dying process was laden with guilt and divisive behavior. She wrestled with personal guilt as indicated by her insistant questioning about why God didn't take her. At no point did H want to be reconciled to the cut off part of herself, her son, and she continued to disassociate from him. She "wanted to die in peace", and may have felt that he was too much of a reminder of her troubled life.

When she died, S was relieve, and she indicated shame and guilt over the resultant behavior of the brother. She felt she might have advised her mother to see him, but she "didn't want to force it."

The G family did not die peacefully. Any transformation effects remain to be seen.
"G" FAMILY CHART

<table>
<thead>
<tr>
<th>THEMES</th>
<th>IMAGES</th>
<th>PATTERNS</th>
<th>ROLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation</td>
<td>Terrible, devouring mother</td>
<td>Anger, denial, denial</td>
<td>Blamer</td>
</tr>
<tr>
<td>Drowning</td>
<td>Victim, silence</td>
<td>Grasping</td>
<td>Placater</td>
</tr>
<tr>
<td>Dismemberment</td>
<td>Scapegoat</td>
<td>&quot;Going to pieces&quot;</td>
<td>Identified Patient</td>
</tr>
<tr>
<td>Formlessness</td>
<td>Decay</td>
<td>Chaos</td>
<td>Distracter</td>
</tr>
<tr>
<td>Fusion</td>
<td>Great mother</td>
<td>Comfort</td>
<td>Placator cooperation</td>
</tr>
</tbody>
</table>

ANNIHILATION

LIBERATION
Dominant Archetypal Theme: The Hero

S Family

Sex: Female
Age: 61
Diagnosis: Cancer of the liver, metatasis
Length of care: one and a half months
Education: high school
Occupation: apartment manager
Religion: none
Husband: 65

Occupation: retired, handicapped
Education: some college
Religion: none

Age of Family: 30 years
Family Structure: nuclear, closed, husband has five grown children from former marriage (no connections).

Recent losses: none
Family present at intake: husband, husband's brother. (patient absent)

Role code:
V = dying person, wife
H = husband
B = brother of husband

Role symbol connections-map
V to H = wife to husband as Blamer
V to B = wife to brother, none*
H to V = husband to wife as Identified Patient
H to B = husband to brother as Identified Patient
B to V = brother to wife as none
B to H = brother to husband as Computer

*None indicates no observable connection.
Role Communication, Archetype:

V = Computer - Hero
H = Placator - Victim/Identified patient

S Family - The Hero

Therapeutic Focus: The Struggle

V chose surgeries and chemotherapy after her diagnosis given four months prior to this contact. V had been in the hospital twice seeking cure or remission of her illness and fought the cancer all the way. At the time of initial contact V had just come home from the hospital and was told there was nothing more that could be done.

Therapeutic Focus: Avoidance, weakness, denial, grief;

Drowning, Hero

First visit: Contact was made at home with team nurse. Husband and husband's brother from out of state were present and skeptical about any help for V. V was not in room and husband protected us from seeing her by saying she had just gone to bed and was sleeping. Brother asked many questions about type of care and was spokesperson for brother. Husband (H) was emotionally and physically handicapped. He cried almost constantly and loudly blew his runny nose. His hands and head shook and he couldn't talk clearly. He was retired because of diabetes, heart condition and general weakness. He was stooped, walked with a cane, and shuffled when he walked. Brother was younger, a businessman, and, on first visit, appeared to be caretaker of H. Questions to H were met with fears and
sobs. Therapist gave permission to H to cry and talked about crying as appropriate to the situation. Once permission was given H started to control his sobs and he began to talk. He told of the years of their marriage (his second), his work in business as engineer, his diabetes, about H (who he repeatedly called by a nickname instead of her given name) and the work she did as secretary. He said they had moved to area five years ago and that V managed the apartments they now lived in. V "did everything" and was a "wonderful person" and then he started to cry. She took care of him and was capable and strong. Brother agreed - added that it was a shock to see her ill. H said he thought he'd "go first", not her. He never expected it. H thinks they can still lick it. He has not discussed the terminal diagnosis with her yet.

**Therapeutic Focus:** Anger, depression, loneliness, sorrow, acceptance; Distraction

Second visit: V on couch in living room. Visited for one hour. V not talkative, flattened effect. Responded to all questions in short manner. Volunteered information only after much discussion of what her illness and history were. Said she didn't have too many friends she wanted around at this time. Teared at the mention that she might be lonely for company, but said people would just pry and snoop about her condition. "They don't say what they want." H cried openly, sat in chair near couch and was part of the
exchange. Talked for V at times when she didn't answer right away. V began to be more quiet the more H did that. Did not respond when therapist asked her to respond to questions H had answered. Therapist permitted H to cry, saw that V drew away from him when he did. She didn't answer when asked how his crying made her feel. V said they haven't talked about things yet. V knew she was very ill, didn't want to talk about illness or what doctors have told her. Paid a lot of attention to scenery outside her window. Responded with direct look or half smile to therapist only when the scenery is talked about, or the weather, or things the therapist said about what she likes to do. V said she doesn't like to eat, but liked to sleep a lot. Said she "doesn't mind" if therapist comes back. Smiled for first time.

Therapeutic Focus: hope, regret, anger, avoidance, fear;
       Reaping, Dance

Third visit: V feeling better and is barely ambulatory. Shows her scars from operation, swollen legs. Said she wanted to take a small walk later. Hoped she would get better. H not present. V seems more relaxed, willing to talk. Said for four years here she had fought with H; "just sit around and fight", she said. She wished she could go to work again. Appeared not to be aware of her prognosis. Never talked of it. Therapist asked her again what the doctor has told her about her illness. She said
nothing in direct response but repeated she was hoping to go out to work again. V talked much about the plants outside her window and how much they are growing. V also said that H could not get a handicapped license to drive as had been suggested. Offered no specific reason but that he just couldn't. She had been the one to drive and handled all affairs, made the decisions and managed their lives. When questioned about how he would take care of her now that she was seriously ill or how he would get around, she became silent, withdrawn and appeared to be angry, perhaps afraid. H came in before further dialogue occurred and V's demeanor became blank and apparently uninterested. Therapist indicated to H that she will come back when they can continue to talk alone, as it appeared she will not talk in the presence of H.

Short discussion followed about V feeling better. H seemed not too responsive. Said he was tired from doing so much. Suggested he take walk with V if she could go later. He wanted to hear suggestions like that. H talked about the kind of social life they had, playing cards and going to breakfast every Sunday morning at a certain place in town. It was their retreat. He hoped she could get well enough to do that again.

Therapeutic Focus: Hope, denial, depression, alienation;
Computer, Hero, Formlessness

Fourth visit: V on couch again. She slept there now. She
said she watched the changing sky, the plants and the warm sun through the window. H said she was on couch all the time. H noticeably subdued. He said they "hope for the best", that "they'll lick the illness", "a miracle." V said sometimes she does and sometimes she doesn't. And if she doesn't, therapist asked? V replied she hadn't thought about it if she doesn't. If she does get better, she responded, then she planned to get more exercise. Seemed to see lack of exercise and physical activity as a connection to her being ill.

Still didn't want to see any acquaintances. Spoke of one friend, but seemed cautious of too much help from her.

V wanted to get out of house, but replied to therapist that it isn't really boring lying on the couch all the time. Didn't watch TV, just looked outside. V and H said she sleeps ninety percent of the time. H said he wanted to get her out and moving. V didn't care what happened to her. Said she was sick because of chemo treatments. Said she didn't care what happened to her. V said she didn't think too much about things now. Therapist didn't know what to do about the evasion.

H and V spent time talking with therapist about their past. It seemed to be pleasant in their memories. N showed pictures of V and self. V was strong, dominant-looking then.

Therapist asked about the use of H's nickname for V.
They said they liked it better. Throughout all visits V also calls H by his last name, never his first.

**Therapeutic Focus:** Withdrawal, silence, vegetation, death

**Succeeding visits:** The focus of several short sessions following was to rehabilitate H to get a driver's license. Therapist structured suggestions about his capability by remembering with him how he was before these handicaps and what it was like to go about on his own. V listened but didn't say a word. V was much weaker - ill. Often in these conversations she turned her face to the back of the couch. Therapist now took up silences with her by often being silent also, and merely sitting with her. H accepted the silences without objection and putters around the apartment.

Therapist sensed conflict building in V about her situation. Therapist talked of the winter scenery as seen from the window, about spring, new growth, the sun. Therapist, on direction, moved an indoor plant to outside patio. Talked about the benefits of rain. V listened and showed non-verbal attention to this talk.

**Therapeutic Focus:** sorrow, separation

On one of the last visits, V talked about her sister and how close they were; the only one in may family, she added. Said she died just the year before.

**Therapeutic Focus:** sorrow: Visitation of the deceased,

Hero
The visit following V talked of seeing her sister. Therapist asked where? V answered here, in bedroom. Therapist asked what they talked about. V answered they didn't talk; just had a good feeling seeing her again. Therapist said she must really mean a lot to her. While this conversation goes on V looked therapist straight in the eyes. V added that her sister came to her a lot now. Therapist agreed by repeating the statement. With H, therapist praised his care-giving abilities and encouraged H to say whatever he needed to V and not to hold back. H started to tear and didn't speak.

**Therapeutic Focus:** Weakness, waiting; Decay, Silence.

Last visits. Team nurse and therapist made V comfortable and encouraged H to touch her, to do physical care of V and to be with her. V was weaker than ever. Therapist gave V ice chips on bed. V kept looking out of bedroom window where a plant was on a rail outside. One like it was on side table near bed. It was drying out and needed watering. The day had been raining. Therapist suggested she put plant outside. V nodded agreement, continued to stare at plants. Therapist put plant on rail with other one and said the plant was dying and asked should she water it? V said an emphatic, strong no, and looked directly at therapist.

Therapist sat on bed with V and remained quiet with hand on hers for a length of time. V weaker, pulse weak
and nurse gave towel bath. V continued to hold therapist's hand. Therapist asked V if she had said what she needed to to N. V looked out window again, didn't talk.

Therapist left after sitting a long time with her in silence. At door therapist turned and said she'd be going after she spoke with H. V looked directly at therapist and said "you don't have to come back now. We'll call you when we need you." Therapist sensed this was a final statement and said goodbye for the last time.

**Therapeutic Focus:** Finished business, sorrow, goodbye; Journey.

**Last visit:** V died in the early morning of the next day. H called immediately and the nurse and therapist went to him. H recounted what had happened. V had been moved later that night back to the couch. H slept in the living room near her. After midnight V woke and asked for her pills and water. H got them and held her to prop her up so she could take them. She refused the pills and started saying that H should get her slippers - that she wanted to go. Help her up, she insisted, and get her clothes. She had to go. H said he became agitated and worried that she was being unreasonable, for she was insistent and upset that he wouldn't help her. V told him she needed to get dressed and go. Go where? he asked. V replied to breakfast and said it was Sunday, wasn't it? H said she fell back into his arms and said that she loved him. He told her he
loved her. He cried and repeated the story over and over.

Addenda: H's recovery and adjustment were remarkable. From the time V's body was carried from the house he started to be more calm and to pull himself together. H obtained a handicapped driver's license by himself, bought himself a new suit, made all funeral arrangements and soon stopped walking with a cane. He stood straighter, head held up and he did not shake at all. When he cried, it was quieter and not hysterical as before. He talked frequently about those last moments with V and seemed to take strength from what had happened.

Summary
Chapter four has presented a justification for the use of the case study approach in an innovative area of investigation along with the analysis and evaluation of five specific cases. The derivation and use of Omega Therapy, which combined Satirian family process and Jungian Archetypal themes and images is described. Ways in which the Omega therapeutic approach may be applied and utilized are discussed within the context of five selected cases. For each case of family presented a corresponding summary chart was presented showing the Archetypal themes and images with that family's communication patterns.

The cases were coded by initials and characterized by
<table>
<thead>
<tr>
<th>LIBERATION</th>
<th>ANNIHILATION</th>
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<tbody>
<tr>
<td>Announcement</td>
<td>Struggle</td>
</tr>
<tr>
<td>Visitation from the dead, hero</td>
<td>Water, victim</td>
</tr>
<tr>
<td><em><strong>ANNIHILATION</strong></em></td>
<td>Water, clock, clinging tree</td>
</tr>
<tr>
<td><em><strong>LIBERATION</strong></em></td>
<td>Whisitation from the dead, Hero</td>
</tr>
<tr>
<td>Assimilation</td>
<td>Overgung, gapping</td>
</tr>
<tr>
<td>Assimilation</td>
<td>Depression</td>
</tr>
<tr>
<td>Computer</td>
<td>Plaster</td>
</tr>
<tr>
<td>Computer (strength)</td>
<td>Distraction</td>
</tr>
</tbody>
</table>

**Themes**
- Formlessness
- Drowning
- Struggle

**Archetypal Images**
- Decayng vegetation
- Water, victim
- Water, clock, clinging tree

**Patterns**
- Chaos
- Overgung, gapping

**Roles**
- Distraction
- Plaster

**Communication**
- Plaster
- Distraction
- Computer (strength)
- Computer
identifying a dominant archetypal theme.

In addition to presenting a summary of crucial sessions, an analysis and evaluation of each family's selected session relating archetypal themes and communication patterns was conducted.

The W family was presented with a dominant archetypal theme of The Marriage that incorporated other images and lesser themes such as clinging, Terrible Mother, and The Child. Dyadic communication patterns in the family complemented and energized each other as Blamer to Placator and Computer to Distracter. There appeared to exist equal valence in both annihilation and transformation processes as seen in the family communication patterns and archetypal representations and transformation of dysfunctional attitudes seemed possible.

The P family was presented with a dominant Archetypal theme of The Child in which the lesser themes of Terrible Mother and the Labrinth gave rise to complimentary images in both annihilation and liberation processes. Communication patterns and roles remain for the most part dissonant within the family. However, some integrative patterns were indicated with the positive aspects of the Placator and Identified patient. There existed an uneven balance between the annihilation and liberation processes but with distinct indications that a liberation theme was possible to enable family transformation.
The E family was presented with a dominant Archetypal theme of the Dance, indicating a rich pattern of intricate communication roles and archetypal images that complimented one another in both annihilation and liberation processes. Equal valences of archetypal representation and communication dynamics indicated a strong potential for positive family transformation to occur.

The G family was presented with a characterizing dominant Archetypal theme of the Scapegoat in which the lesser themes of Devouring Mother and silence added to the dominant, destructive Archetypal representations. Themes of annihilation were in preponderance as seen in both archetypal and communication representations and in the final, uncertain image of the positive Great Mother that may have occurred for one family member. Such an image may have indicated a slight potential for the transformation of destructive family patterns.

The S family was presented with a dominant Archetypal theme of The Hero, which characterized the negative Hero aspects in dysfunctional communication patterns and roles such as distracting, computing, and placating. Some annihilation symbols were vegetation and silence. However, the positive aspects of the Hero arose and complimented the liberation symbol of a visitation from the dead strongly augmenting the potential for the transformation process in the survivor.
It is important to note that in all cases the potential for either annihilation or liberation of family patterns and intrapsychic dynamics rests in the inherent tendency of flow between both processes. There always exists potential for either process to dominate yet though annihilation and liberation appear to be polar activities, their dynamics are interrelated and bound to one another.
CHAPTER V

Summary and Implications for Further Research

The purpose of Chapter Five is to summarize the study and make suggestions for further research.

Chapter One presented the format of the study and justified the need for such a study related to the absence of any clear, systematic therapeutic approach to use with the dying and their families. Chapter One suggested that psychosocial concepts of care for the dying are in the pioneering stages and are flexible enough to encompass the psychotherapeutic uses of symbolic themes and images and the systems concepts of family therapy. It was contended that such a combination of therapeutic modalities would provide a specific lens by which to focus on intra-psychic family dynamics that affect both the dying and bereavement process.

Chapter Two presented a review of the literature which delineated a brief background and history of the death and dying field and which also explained the need for the formulation of a therapeutic approach for the benefit of the caregiver as well as the dying person and his/her family. Discussed in Chapter Two were: (a) the Hospice concepts of terminal care, (b) the existing ambivalence to a therapy with the dying, and (c) family dynamics and their relationship to the dying process. Satirian Family therapy
and Jungian therapeutic uses of Archetypal images and themes were individually presented and their combined application suggested as a synthesis for the basis of an effective therapeutic approach for work with the dying and their families. Such a therapeutic approach was described as viable and fruitful for more effectively caring for the dying-transforming family.

Other family and imagery-based theories were noted as they offered indications of pre-existing inclinations toward this study's suggested therapeutic approach.

Chapter Three presented this study's therapeutic approach called Omega Therapy and characterized the dying-transforming family, their needs, and their perceived psychological condition. Specific Satirian and Jungian strategies incorporated in Omega Therapy were presented and explained in their relationships to the dying-transforming family and the dying process. The importance of employing Archetypal themes and images and family dynamics in Omega Therapy was presented and defended. Finally, the therapist's role in the therapeutic process with the dying-transforming family was explained. Therapist's roles differing from those of usual therapies were highlighted. A schematic of Jungian/Satirian archetypes and systems accompanied the text to illustrate relationships of Themes and Images to Communication Patterns and Roles.

Chapter Four described the study's methodology. Case
studies were used. Weaknesses and strengths of the case study approach—especially as applied to unexplored areas of research and procedural methods were discussed. Also, in Chapter Four, five case studies were presented and then analyzed and evaluated in the context of Jungian archetypal themes and images along with Satirian family systems and communication patterns. Accompanying the findings were schematics for each case depicting the association of archetypal material and communication patterns.

The assumptions of this study are that the dying process is a uniquely important and potentially integrating event in the life of the individual and family and that therapeutic support and intervention with the dying needs to therefore be in a special form. This study also assumes that family therapy is the appropriate mode of therapeutic intervention and that therapeutic uses of archetypal representations as seen in images and themes further enhances the therapist's diagnostic and clinical ability to care for the dying. Such a synthesis of therapeutic modalities, it is believed, can provide a systematic and effective approach by which the intended therapeutic goals of constructively concluding life's business and accepting loss by saying goodbye are accomplished. It is further believed that such an approach may be seen to provide important therapeutic tools in dealing with the bereavement process, especially because it enables the therapist or caregiver
to operate from a firm foundation. Such a foundation (it is hoped) may provide the necessary energy protection and prevention of undue stress often related to treating the dying and their families.

In conclusion, the applications of Omega Therapy in this study suggest that further specific and detailed research be undertaken in order to support its general use as an effective therapeutic approach to treating the dying—transforming family. Further research may include (a) investigations of the therapist's own archetypal themes in relationship to their own dying process and further, what relationship the therapist's own themes and images have in therapeutic interactions, (b) the effects of archetypal influences in staff relationships and stress in working with the dying, and (c) the effective uses of archetypal material in general family therapy.
Ackerman, Nathan, M.D., Psychodynamics of Family Life, Basic Book, Inc., N.Y. 1958

Ackerman, Nathan, M.D., Family Psychotherapy and Psychoanalysis: The Implication of Difference in Family Process, Basic Books, N.Y. 1970

Allport, Gordon, Becoming: Basic Considerations for a Psychology of Personality, Yale University Press, New Home 1955


Bandler, Richard
Grinder, John

Bell, Paul
Fisher, Jeffery


Dobihal, Jr., E. "Talk or Terminal Care", Connecticut Medicine, July, 1974, Vol. 38, #7


Eliade, Mircea, Myth and Reality, Harper & Row, Publisher, N.Y., 1963


Gorser, Jeffrey, *Death, Grief and Mourning*, Doubleday Publishers, N.Y. 1956


Hess, Robert and Handel, Gerald, *Family Worlds*, University of Chicago Press, Chicago 1959


Hochberg, Donna, "Dance of Sorrows" performed at Moorpark College, Moorpark, CA, 1978 and University of Southern California, Los Angeles, 1979. Hochberg (originator)


Koestenbaum, Peter, Managing Anxiety, Prentice Hall Inc., (Engelwood Cliffs), N.J. 1974

Kubler-Ross, Elizabeth, On Death and Dying, Macmillan Publisher, 1969

Kubler-Ross, Elizabeth, Dying as the Final Stage of Growth, Prentice-Hall, Inc. N.J. 1975

Kutscher, Austin H. & Goldberg, Michael R. Caring for the Dying Patient and his Family Health Science Publishing Corp., 1973, N.Y.

Lamerton, Richard, lecture notes, 1972

Marjula, Anna, The Healing Influence of Active Imagination in a Specific Case of Neurosis Shippert & Co., Zurich, Switz. (undated)

Mount, Balfour, personal communication, 1979


Satir, Virginia, personal communication 1979

Saunders, Cicely, "Last Stages of Life", American Journal of Nursing, March 1965: p. 70-75


Shoenberg, B.; Carr, A.C.; Peritz, D; and Kutscher, A.H., Psychosocial Aspects of Terminal Care, Columbia University Press, N.Y. 1972

Strauss, Ruth, "Archetypes of Separation", in The Archetype
Guggenbuhl-Craig, Adolf, Ed., Verlog S.Kargen AG
Basel, Switzerland 1964

Stryker, Sheldon, "Symbolic Interaction as an Approach to
Family Research", in Symbolic Interaction: A
Reader in Social Psychology Manual, Jerome &
Meltzer, Bernard, Allyn and Baxon, Inc. Boston
1967, 1972, 1975

Von-Franz, Marie Louise, "Some Archetypal Images Around
Death", Panarion tapes, 1976

Von Franz, Marie Louise, personal communication 1979

Weisman, Avery, "Psychosocial Consideration in Terminal
Care", in Shoenberg, B. et al. Psychosocial
Aspects of Terminal Care, Columbia Univ. Press,
N.Y. London 1972
APPENDIX
<table>
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<th>Family</th>
<th>Archetypal Themes</th>
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<th>Communication Patterns</th>
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<td>Separation</td>
<td>Terrible Mother</td>
<td>Denial</td>
<td>Blamer Computer</td>
<td>Change growth</td>
<td>The Child</td>
<td>Insight</td>
<td>Distracter (congruent)</td>
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<td>Clinging Tree</td>
<td>Displacement</td>
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<td>Union, Fusion</td>
<td>The Mother</td>
<td>Com-fortunate</td>
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<td>Blamer</td>
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<td>Worthlessness</td>
<td>Placator</td>
<td>Time</td>
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Assessment Form Checklist

1. Religion
2. Progress of illness
3. Physical location of disease
4. Age of family
5. Family members
6. Family present
7. Who talked most, why.
8. Family member most accounted for
9. Family member least accounted for
10. Occupation
11. Hobbies, interests and favorite pastimes.
12. What the individual knows of own illness
13. Who is the Identified Patient
14. Who appears to require the most attention
15. State sources of family stress
16. Family's perception of itself
17. Perceived family support systems
18. Previous crisis reactions
19. Setting and uses of home environment
20. Significant friends
21. Pets
Assessment Form: Demographic Elements

1. Age: ______ years ______ months

2. Sex: ( ) M ( ) F

3. Type of illness: ________________________________

4. Length of illness: ___ years ___ months ___ weeks

5. Type of treatment: ________________________________

6. Educational level: ( ) High School
   ( ) BS ( ) BA
   ( ) MD
   ( ) Community College
   ( ) MS ( ) MA ( ) PhD
   ( ) others

7. Occupation: ___ years ___ months ___ weeks in present job.

8. Spouses occupation: ________________________________

9. Spouses educational level: ( ) High School
   ( ) BS ( ) BA
   ( ) MD
   ( ) Community College
   ( ) MS ( ) MA ( ) PhD
   ( ) others

10. Economic status: _______ total family income
    _______ assets
    _______ other

11. Children, their name, ages and sex:
    _______ name _______ sex _______ age
    _______ name _______ sex _______ age
    _______ name _______ sex _______ age
    _______ name _______ sex _______ age
    _______ name _______ sex _______ age

11. Rural, urban or suburban: ________________________________

12. Referral source: ________________________________