1994

Scapegoating God : Attribution to supernatural causality in family system theodicies a family's response to terminal illness

Trisha Le Crissman
Loyola University Chicago

LOYOLA UNIVERSITY CHICAGO

SCAPEGOATING GOD:
ATTRIBUTION TO SUPERNATURAL CAUSALITY
IN FAMILY SYSTEM THEODICIES
A FAMILY'S RESPONSE TO TERMINAL ILLNESS

A THESIS SUBMITTED TO

THE FACULTY OF THE GRADUATE SCHOOL

IN CANDIDACY FOR THE DEGREE OF

MASTER OF ARTS

INSTITUTE OF PASTORAL STUDIES

BY

TRISHA LE CRISSMAN

SCHAUMBURG, ILLINOIS

APRIL 1994

ACKNOWLEDGEMENTS

This thesis is the fruit of energy and effort from numerous sources. First, I would like to thank Dr. Ann O'Hara-Graff, Thesis director, and Fr. Robert Sears, S.J., Reader, for their guidance and support on this project from its inception.

Second, I am indebted to Richard Ley and to his family for sharing their personal experience and struggle with cancer. For their gracious, open and honest sharing, and the love and encouragement which Richard has shown me in this and many other projects, I am grateful beyond expression.

Kathryn Schnidt, my colleague and friend, has offered encouragement, support, intellectual challenge and truly pastoral, theological insight on this work and many others. I am honored by her friendship and her sharing.

Lastly, this work would not be possible had it not been for the love, encouragement and support of my family during my own battle with cancer and beyond. To them and to my God--for my life and future--I am eternally grateful.

TABLE OF CONTENTS

CHAPTER 1

LESSONS ABOUT LIVING: WHAT CANCER HAS TAUGHT ME

You may not be given long to live,
But live as long as you are given.

Greg Anderson

No one wakes up in the morning and expects to be diagnosed with a terminal illness. I didn't. The thought of having something seriously wrong with me had never entered my mind. The reality of life is, however, that one cannot predict what tomorrow will bring, and when it brings illness, pain and suffering, that reality becomes cold and stark.

On the other hand, most people don't expect to go through life without ever getting sick. Although some of us are more healthy than others, we are all subject to our humanness, all susceptible to occasional illness and the maintenance of a physical, mortal body.

It is not surprising that as a society vastly concerned with time, energy and productivity, we seek to remedy our ills--to take away the pain--without much attention to how our flu came to be or why certain foods upset our stomach. I understand this apparent apathy with regards to common ailments as directly related to the fact that we can have a certain degree of control over these ills

by merely taking a trip to the drugstore. There are very few common, physical ailments which cannot be remedied with over-the-counter minor miracles.

On the other hand, attitudes and feelings surrounding serious or terminal illness are quite different. When we have little or no control over the diseases that plague our bodies, we tend to sit up a little straighter. Lack of control and understanding as to the genesis, course, and/or outcome of serious, life-threatening illnesses bring about feelings of frustration, confusion and dismay. Individuals and their families may be overcome with questions of "Why?" and in their search for meaning and context, may feel isolated from other family members, their friends, and their God.

It is refreshing to see that much has been written as of late on the importance of the maintenance of self-esteem and social relationships for terminally ill patients and their families. I am concerned, however, as a pastoral counselor working with the terminally ill, that research in various fields tends to neglect the spiritual crises of patients and their families inherent in their struggle with the experience of terminal illness. What of the spiritual life and relationship with God of the patient and the family? What of the changes in the relationship which patients and family members experience with their God during their coping process and beyond? What of the crises of

faith which families with a terminally ill member face with confusion and feelings of anger, betrayal and abandonment, when questions to their God remain unanswered? What happens to the devotion, the reliance, and the faithfulness of those who struggle with core issues of their faith when faced with the suffering and possible death of a loved one?

I believe that the spiritual realm and questions such as these deserve much attention and concern in regard to the coping process in terminal illness. As a cancer survivor, I understand that this area is especially important because I have experienced first hand how my relationship with my God was challenged and strengthened by my struggle with terminal illness.

In exploring the crises of family systems within this spiritual realm, it is not my intent to be so theologically, psychologically, or academically inclined that it bears no relevance for the lay family experiencing terminal illness and the stages of their coping in crisis. It is my hope that by grounding this investigation with my own experience and that of my family, it will provide a sort of reality check for the real-life experience of struggling with spiritual crises in terminal illness. I have, therefore, chosen to begin this investigation with a brief narrative of my own cancer story, shared with the insight from the stories of others who have also experienced first hand the challenging crises which illness poses. As narrative gives

us the experience, when I share my story, hopefully it will transform you as it has transformed me. In what follows, I will share with you my struggles, my insights and the areas my life has been touched most by this bittersweet experience. I will share what life has taught me about God, what God has taught me about my family, and what cancer has taught me of both.

In addition, it is my hope that my experience with cancer and my family's experience with terminal illness will provide a sort of vantage point from which to discuss this notion of scapegoating God and the crisis of terminal illness within the family system.

About God

In August of 1991 I was diagnosed with Hodgkin's Lymphoma, Stage IIB. There were no blatant warning signs, there was no preparation time. I was 25 years old, working full-time and enjoying my emergence into the professional sphere after having spent much of my time in academic pursuits. I woke up one Monday morning with an irregular heart rhythm, and by Thursday afternoon of that same week I had undergone three days of intensive investigative/ exploratory surgery and testing and had been diagnosed with a rare form of cancer of the lymph system.

When the oncological surgeon came to my hospital room two hours after I had been admitted and told me I had a tumor the size of a football in my chest cavity, my

immediate feeling was a sensation similar to that of a dream-like state where everyone had the objective of playing this huge practical joke on me. This description obviously falls under some sort of dissociative state, where I had split from the experience which was too much for me to bear. I truly thought that this was happening to someone else; as though I had separated from my body and was watching this drama play out in someone else's life.

Once the Hodgkin's had been confirmed through pathology reports, the team of doctors began to lay out the steps necessary for me to take in order to save my life. It was necessary for me to undergo six months of aggressive chemotherapy, followed by two months of radiation. They told me that with no treatment I would most likely be dead within two years. I was fortunate in that my lymphoma had not spread to more than one localized area, which provided optimal setting for chemotherapy and radiation treatments. Because of the speed with which Hodgkin's Disease spreads, I was given one week to decide on my course of treatment, or I could be faced with a different scenario if the lymphoma spread to additional areas.

In hindsight, the lack of time to explore alternative methods of treatment and to ponder a whole slew of "what if's" worked to my advantage. Had I several weeks to think about the treatment to come and its ramifications, I wonder whether I could have gone through with it. The one-week

time frame provided me and my family enough time to seek a second opinion, explore different oncologists and their "bedside manners," for the insertion of a long-term catheter and for my first chemotherapy treatment to be given exactly seven days from my discharge from the hospital.

This time frame also sped up my psychological need to cope with the new news of having a serious, potentially terminal illness. The experience of watching this catastrophe unwind in someone else's life came to a breach two days before my chemotherapy began. Up until that point I had been functioning pretty well, having tests done as I was told, and remaining fairly together mentally and physically.

One afternoon early that first week, however, I had what I call an existential slap in the face. The environment was perfect for me to feel free to be with myself; up to this point I had had family and friends around practically twenty four hours a day. I think this opportunity to be alone was all I needed for the flood of emotions that I had been experiencing and repressing for the past week to come pouring out.

That afternoon is still very clear in my memory. I remember screaming at the top of my lungs for what seemed like hours. I don't recall directing my screams of "Why" to myself, or others or to God specifically, but in reflecting on this time later, I feel that my questions were directed to my God, the only One who could answer these questions

with no end. Remembering that time for me is very powerful, and the feelings associated with the release of that pent-up emotional hurricane are still quite touching. It is no wonder that in remembering, I still feel the strength behind those moments, for the anger I was feeling was so powerful that I felt the earth would quake and crack from its intensity.

My moments with God and with self which followed, especially during my six months of chemotherapy were not as intensive, but were very powerful nonetheless. I can remember a period of about six weeks, about mid-way through my chemotherapy when every night's prayer resulted in being down on my knees pleading and crying until my body had no strength, until my eyes were swollen shut from tears, and sleep came from exhaustion.

It is this experience with my God which has led me to question the effects of terminal illness on individual and familial relationships with God. Surely my questions to God of "Why is this happening to me?" were not mine in isolation. I could not have been the only one who searched for answers to the question "Why?" and when no answers were found from tangible, practical angles, having then turned to my God for relief in prayer, hoping that God would provide the answers. In turning to God, however, I noticed that along with my wishes and hopes, I was also turning my anger to God. In reflecting back, I know that I was sensitive to

this act, and felt some guilt and shame, but knew throughout that my God could hold my anger, my blame and the incredible shame which followed.

I understand the process I went through of turning my anger and blame to God as being extremely healthy for me psychologically, emotionally and spiritually. It was healthy psychologically and emotionally in that I was able to release the anger I was feeling as a result of my plight, instead of keeping it repressed for fear of its power and ramifications. It was healthy spiritually in that I had to rely solely on my faith that my God could hold and embrace whatever I might throw His way. I know now that I have emerged with a knowledge of a God more powerful, more compassionate, and more grace-filled than I knew prior to my crisis. It has set me free to return to my God when in doubt, when in times of stress - because I have emerged from my cancer experience and dependence on God with a knowledge that ultimately, my God is the only One capable of holding my grief, my anger, and my struggle with the very reality of God's power, omnipotence and love for me. I understand spiritual challenges now as powerful acts of faith, not acts of defiance or of religious blasphemy.

It is this gift of insight and spiritual depth that my struggle has given me which has caused me to look at the process inherent in questioning God, how it effects individual and familial relationships with God, and the

affects of this changed relationship with God on prayer life and on communal worship.

My struggle with cancer enabled me to rely on God not only for healing and for forgiveness, but to hold my anger and my pain, my fear and my confusion. My dialogue with God now encompasses all of my feelings and emotions in this life, not only those which feel comfortable or in line with traditional approaches one might take to a God who is merciful but also just. It is an approach which can embrace what Marie Deans of Richmond, Virginia exemplifies in a recent article on "The Power of Prayer," who's mother-in-law was killed by an escaped convict, crying to God, "Help me, you son of a bitch, help me!"[1] Cancer taught me the lesson that God hears our cries of anger and frustration, that God embraces our fear and confusion as well as our songs of praise and thanksgiving.

About Family

I thought I knew my family before I got sick. After all, we had shared many challenging moments of despair and fright, of unconditional love and supportive acceptance in the twenty-five years we had spent together. I know now that there were depths of experiences of almost celestial quality which we had yet to encounter; moments which would never have graced our lives had we not undergone the

---

[1]"Why We Pray," Life (March 1994): 62.

transformative bonding which terminal illness brought smashing down upon our lives together.

Reflecting back on my family's experience while I was sick brings memories of how I was constantly aware that the experience of my illness was much more difficult for them than it was for me. I **knew** how sick I really was. I was aware of where it hurt, of the way the drugs were effecting me, of my energy level and emotional ups and downs. My family could only rely on my expression of this experience. They could not do chemotherapy for me. This experience of their limitations as human beings and as other-than-me was extremely frustrating and painful for them as well as for me. Each one has conveyed to me that they secretly wished it could have been them, and would have traded places with me in a heartbeat.

This experience was even more powerful for my identical twin sister. Throughout our entire lives, we've always shared our experiences; we have had the same dreams and are motivated by similar interests and drives. Yet she had to let me do this on my own. What an incredibly powerful ontological and existential time this must have been for her. I do not know that I would have weathered the storm of separation that my cancer played upon our intricately woven selves as well as she did. Her ability to let me experience this pain alone has brought us even closer together. A feat I would have thought impossible.

My family's experience of terminal illness has made me question how our family system was able to maintain a sense of cohesion, enabling it to function in the daily realms of work, love, play and rest, while grieving the destruction and the loss, the pain and suffering this cancer brought to us had caused. It has raised questions for me of how family systems must not only rework their structure and patterns of functioning during the illnesses they experience, but also how the system must reemerge from this time, whether with a remission of the disease or facing the reality of the death of one of its members, to function again as a whole, to begin to live again with this new way of being in the world and all that this new existence entails. My cancer experience has taught me the lesson of how powerful the ties that bind us really are, and how these bonds are forever being shaped and formed through our experiences together and the insight we gain from them.

About Living

My new understanding of my relationship with God, and my family's relationship with God and with me, has provided me with new insight into the mystery of life and of human existence. It has given me the courage to question, the strength to understand and to be able to apply the silence that comes from pondering the daily pain, struggle and celebration.

Never before had I known the joy of waking in the

morning with the immediate awareness of the beating vitality of my own heart, pumping life through my being. My experience with cancer and with struggling with my God has allowed the room for me to enjoy and revel in this often trivial and overlooked gift. It is almost as if I have been given an intricately-tuned looking glass through which to enjoy and examine the remaining time I have with self, others, family and with God.

I have heard it stated time and time again that the great obstacle with which we human beings struggle with is our fear of death and of dying. Some claim that it is this fear which pervades all areas of life, which underlies all defenses and struggles with sin. Terminal illness forces individuals and family members to look into the abyss of death, to face the fear from which we spend lifetimes running from. These experiences rub our noses in our own mortality, our own finiteness, our own limitations and shortcomings.

This being so, I probably have received the greatest gift of all from my fight with terminal illness, for I no longer am afraid of dying, and death does not seem as scary, having looked it in the face and fought with its reality. I will admit, however, that I am afraid of what my family would have faced had I not won this great battle. I am fearful of the pain and anguish that my parents would have felt had I not lived through this experience. I struggle

with how my family would have emerged from my loss, how they would go on living productive lives, building strong relationships, and continue to embrace the God of creation and of life itself.

Knowing where my fears exist has made me question even more the way in which we as a society approach the notion of death and terminal illness, and how society and the church might foster such fears instead of embracing measures to work them through. It has made me wonder about the support systems available for grieving parents and siblings; for a grieving family system which must leave a member behind and re-establish relationships with others and with God. These questions too, have been influential in my search for how families are to cope with the loss of a loved one and how this loss affects their social and spiritual functioning. These questions have taught me the lesson that life is a gift, that living is for the gifted in and through God, and that this insight is often lost in the face of suffering and grief.

It is my hope that this story of the struggles and triumphs of me and my family have provided some insight into my motivation for approaching a topic such as scapegoating God and terminal illness. I am also hopeful that it has provided the groundwork for me to begin to talk about the effects of terminal illness on the family system and the family's questions of "Why?" in their search for meaning.

This thesis is an attempt to explore the areas of family systems and terminal illness, theodicy and the search for meaning, and attribution to God in a family's crisis of faith. I understand the process involved in a family system's search for meaning when one of its members suffers from a terminal illness as challenging its understanding of the nature of God. Using resources obtained through research in psychology and theology, I will propose the existence of a stage of **scapegoating God** in a family system's search for meaning and context in the face of the pain and suffering of terminal illness.

In addition to extensive research and personal examination, I have conducted extensive interviews with other cancer survivors and their families who have graciously, openly and honestly shared their pain and struggle with illness, as well as the emotional, psychological, social and spiritual tensions present during their cancer experience and beyond. Their stories have affected me greatly, and I have incorporated their experiences and the insight they have provided me on the coping process in terminal illness into this examination.

What follows is an examination of the family system's process of and purpose for constructing a theodicy questioning God, allowing it to attribute supernatural causality to the genesis, course, and/or outcome of the disease in order to find meaning in the suffering. I hold that this stage of

scapegoating God is key in the coping process of dealing with terminal illness and will examine the shape of this stage in a family's coping process as well as propose that a necessary component of the coping process is movement through this stage of scapegoating God to a place where the family is able to embrace the mystery of their existence and their struggle.

By exploring these areas I hope to offer others insight into overcoming the existential and spiritual isolation of suffering by sharing my own pain as well as the anguish and suffering of others who have fought the great battle with cancer. I make no attempt in this sharing to offer false or easy answers to the problem of suffering and the crises we face with our God. In fact, I admit to my own temptation to reject giving any meaning to suffering at all in order to prevent its compartmentalization. However, I do believe, with the personal conviction born from a long, arduous fight, that there is grace in our pain; that there is redemption in our suffering; and that the greatest struggle of all is for individuals and their families to arrive at a place of reconciliation with their God when the tears no longer prevent us from seeing, when the cries no longer take our breath, and when our hearts can once again rejoice in the saving grace of a God who loves us eternally and of a God who suffers with us in our pain and in our grief.

I begin this exploration in Chapter Two with a discussion of theodicy and general attribution theory. Chapter Three examines the basic theories behind a family systems approach, as well as the experiences, needs, and problems of the family system living with the reality of terminal illness. In Chapter Four I cover some of the same ground while applying theodicy and general attribution theory to the family system's search for meaning and questions to God in its crisis of faith, using the concept of scapegoating as my vantage-point. Finally, in Chapter Five I present some therapeutic and pastoral implications for living with the effects of terminal illness on self, family, and God.

CHAPTER 2

THEODICY AND CAUSAL ATTRIBUTION

Happy is he who suffers and who knows why.

Paul Claudel

One afternoon toward the end of my two months of radiation, I made my way into the sub-basement of a large university teaching hospital where the oncology radiation department was found. It had become routine for me to merely go about my business, walking as fast as I could, avoiding the eyes of strangers who tried so desperately not to stare at my sparse hair. This afternoon caught me off guard for as I approached the end of the long hallway where I was to enter the radiation waiting area, I encountered a scene which I shall probably never forget.

Three nurses hung close to the hospital bed of a young child of maybe six or seven. I could not tell whether this child was a boy or a girl, as the entire head of this young person was covered with medical gauze, and the child appeared to be extremely emaciated. At the fore of the bed was a virtual forest of poles holding IV infusion therapy machines; there must have been eight or ten of them. The three nurses took turns operating a plastic breathing pump, evidently a traveling form of life-support.

The team of nurses and this young person must have been waiting for their turn in the MRI machine, which was why they were positioned in the hall. As I took in the scene and all the meaning and lack of it that this picture entailed, I had a hard time catching my breath. My mind quickly raced to find the reason behind the lifeless body of this young child. What must have happened? Was it a terrible car accident? Was this yet another young victim of Leukemia or a brain tumor? What must the parents of this child be going through? How can things like the suffering of this child happen?

The stark, cold reality of the suffering of this little person could not be escaped. The picture of this child lying listless in that hospital bed, being kept alive by machines and drug therapy would not leave me. Not knowing the cause of this child's suffering drove me to question even more. This picture of such gut-wrenching suffering was so disturbing that I could not help but ask questions about the nature and meaning of suffering. Forget my experience. What I was going through and what my family was experiencing was nothing in comparison to this grotesque example of the ambiguity of human experience and human suffering. How can things like this happen? What follows is my attempt to offer thoughtful responses to the questions raised in my struggle to come to a deeper understanding of the nature of

suffering and the meaning of human experience in light of suffering.

Human Experience and the Ambiguity of Suffering

Janet Ruth Gendler has produced a book of human qualities which is to be read both as inner aspects of the psyche and as characters who exist outside ourselves in their own community. My search for an understanding of human suffering as essential and as alive and applicable to our experience of being human led me to her version of suffering.

> Suffering teaches philosophy on a part-time basis. She likes the icy days in February when she can stay home from school, make thick soups, and catch up on her reading. With her white skin and dark hair she even looks like winter. She has a slender face and dramatic cheekbones.
>
> Suffering's reputation troubles her. Certain people adore her and talk about her as if knowing her gives them a special status. Other people despise her; when they see her across the aisle at the supermarket, they look the other way. Even though Suffering is considered a formidable instructor, she is actually quite compassionate. She feels lonely around students who dislike her. It is even more painful to be around those who idealize her. She is proud only because she recognizes the value of her lessons.[1]

Gendler helps paint the picture of the complexity with which we approach the subject of suffering. Finding value in the lessons of suffering is not such an easy task. Stanley Hauerwas has stated that to see the value of suffer-

---

[1]Janet Ruth Gendler, The Book of Qualities. (Berkeley, CA: Turquoise Mountain Publications, 1984): 31.

ing we need only ask what we would think of anyone who did not have the capacity to suffer (including God):

> Such a person could not bear grief or misfortune, and thus would in effect give up the capacity to be human (or divine). For it is our capacity to feel grief and to identify with the misfortune of others which is the basis for our ability to recognize our fellow humanity.[2]

It is not difficult to understand the complexity of suffering when we look to stories such as the one I described above of the child in the grip of death at the hospital. The suffering of the young and innocent is the most difficult to understand. Yet in asking questions about the value and meaning of any suffering we often find ourselves almost at a loss for where to begin.

Those who have explored the nature of suffering at great length usually begin from the understanding that suffering cannot be understood apart from human experience. John Maes, for example, concludes that suffering must be examined in light of personal, interpersonal, and ontological arenas for understanding human experience.[3] He defines human suffering as "a distressing state of human life arising from stress or tension in any part of the human interactive system - physical, psychological, interpersonal,

---

[2]Stanley Hauerwas, Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church. (Notre Dame, IN: University of Notre Dame Press, 1986): 25.

[3]John L. Maes, Suffering: A Care Giver's Guide. (Nashville: Abingdon Press, 1990): 28.

or social and spiritual."[4] The most critical aspect of the stress or breakdown which occurs in suffering is the loss of meaning and understanding. Maes goes on to state that making sense of suffering, to find meaning in our despair, may be the most difficult and inescapable task we face as human beings.

Central in our attempt to understand suffering within the realm of human experience is the necessity for us to understand that suffering cannot be understood apart from context. Hauerwas states that our inability to analytically define suffering offers insight into the fact that any use of the notion of suffering is context dependent. Assuming that suffering is a universal phenomena negates the fact that suffering can only be talked about analogically through the use of paradigm.[5]

In looking to experience for defining suffering within the human context, issues such as the centrality of meaning, the role of pain, its duration and intensity, and the function of despair and hope in suffering are crucial areas to explore within the realm of human experience. A look to our human context reveals that we make attempts to frame our lived experiences within some kind of meaningful context. Being able to understand and make sense of our

---

[4]Ibid., 34.

[5]Hauerwas, Suffering Presence, 30.

existence is central to what it means to be human. Life experiences such as suffering are most intense when we are unable to locate our experience within a meaningful context. It is apparent, therefore, that the centrality of meaning in human existence and the human propensity for seeking out meaningful contexts from which to interpret life experiences must be considered in any thorough exploration of an attempt to understand the ambiguity of suffering and human experience. What follows is an in-depth look at the centrality of meaning in human existence and our consequent need to search for understanding and context.

The Search for Meaning: General Attribution Theory

It is generally accepted that a fundamental characteristic of human nature is the need for and ability to seek out meaning and understanding. As we have seen from Maes' discussion on suffering, this essential, innate characteristic to understand our environment and why things are the way they are is all the more true with regard to human suffering. Part of the coping process for those who are suffering and those who minister to the suffering necessitates in-depth searches for the meaning and context of the suffering.

Coping is generally viewed as a process through which individuals try to understand and deal with significant

personal or situational events in their lives.[6] Attempts to understand and to explain such events are made in order to alleviate the fear and threat which foreign or unfamiliar events create. Any event of unknown origins or one which is not completely understood is often interpreted as signifying potential injury and, consequently, is regarded as threatening. In order to minimize the fear aroused by threat, human beings make attempts to establish beliefs which serve as guides to our action and understanding in coping with the threat.[7]

These beliefs most often concern the **cause** of specific events. The manner in which individuals draw inferences concerning the causes of observed events is the concern of **attribution theory**. The problem most frequently addressed by attribution theory concerns the observer's effort to determine whether an event was caused by external or internal factors.[8] Attribution theory has been used to explore the manner in which individuals draw inferences concerning

---

[6]Kenneth I. Pargament et al., "God Help Me" (I): Religious Coping Efforts as Predictors of the Outcomes to Significant Negative Life Events," American Journal of Community Psychology 18 (1990): 795; see also R. Lazarus and S. Folkman, Stress, Appraisal and Coping. (New York: Springer, 1984).

[7]Morton Bard and Ruth B. Dye, "The Psychodynamic Significance of Beliefs Regarding the Cause of Serious Illness," Psycholanalytic Review 43 (1956): 146.

[8]Robert J. Ritzema, "Attribution to Supernatural Causation: An Important Component of Religious Commitment?" Journal of Psychology and Theology 7 (Winter 1979): 286.

such areas as personality characteristics of others, the causes of success and failure, responsibility for an accident, and one's own attitudes and characteristics.

Attribution theory assumes a fundamental human propensity to make sense out of the world and experiences to understand the causes of events.[9] Attribution theory maintains that when one encounters a sudden threat or changes in one's environment, one will initiate a causal search in an effort to understand the reasons for that threat or change.[10] A key underlying assumption present in much of the research available is that individuals attribute characteristics, intentions, feelings and traits to objects and individuals in their world in order to make sense of their lives. Research has specified a number of common causal agents including self, chance, others, natural forces, and God.[11]

---

[9]Bernard Spilka and Greg Schmidt, "General Attribution Theory for the Psychology of Religion: The Influence of Event-Character on Attributions to God," Journal for the Scientific Study of Religion 22 (1983): 326.

[10]T.A. Pyszczynski and J. Greenberg, "Role of Disconfirmed Expectations in the Instigation of Attributional Processing," Journal of Personality and Social Psychology 40 (1981): 31-38; and P.T.P. Wong and B. Weiner, "When People Ask "Why" Questions and the Heuristics of Attributional Search," Journal of Personality and Social Psychology 40 (1981): 650-63.

[11]Kenneth I. Pargament and June Hahn, "God and the Just World: Causal and Coping Attributions to God in Health Situations," Journal of the Scientific Study of Religion 25 (June 1986): 194; see also H. Levenson, "Activism and Powerful Others: Distinctions Within the Concept of I-E Control,"

Kelley has presented the most systematic statement of attribution theory, stating that as attributional search is thought to be initiated so as to understand, predict, and control threat, it may be especially functional early on in the adjustment and coping process.[12] By making attributions to causes, individuals create a logical, structured world - one that is understandable and predictable, and to a certain extent, controllable.[13]

Kelley and others have proposed that attributions are made for a number of reasons: 1) to exercise cognitive control over one's world; 2) to seek meaningful explanations of reality; 3) to maintain and/or enhance self-esteem, or perceived freedom. In addition, it is theorized that religious people often realize these motives in terms of spiritual referents such as God or personal faith.[14] I will explore the application of general attribution theory to the

---

Journal of Personality Assessment 38 (1974): 377-83.

[12]H.H. Kelley, Attribution in Social Interaction. (Morristown, NJ: General Learning Press, 1971); and Shelley E. Taylor, Rosemary R. Lichtman, and Joanne V. Wood, "Attributions, Beliefs About Control and Adjustment to Breast Cancer," Journal of Personality and Social Psychology 46 (March 1984): 490.

[13]J.E.W.M. Van Dongen-Melman et al., "Coping with Childhood Cancer: A Conceptual View," Journal of Psychosocial Oncology 4 (Spring/Summer 1986): 154; H.H. Kelley, "Attribution Theory in Social Psychology," in David Levine, ed., Nebraska Symposium on Motivation. (Lincoln, NE: University of Nebraska Press, 1967): 192-238.

[14]Spilka and Schmidt, "General Attribution Theory," 327.

psychology of religion later in this investigation.

If we conclude that most traditional approaches to attribution theory focus on a general desire to understand and seek meaning in the world and an attempt to control and predict events, then we can assume that the attribution process is motivated by 1) a need or desire to perceive events in the world as meaningful; 2) a need or desire to predict and/or control events; and 3) a need or desire to protect, maintain, and enhance one's self-concept and self-esteem.[15]

Spilka, et al., has suggested that attributional processes are initiated when events occur that 1) cannot be readily assimilated into the individual's meaning belief system, 2) have implications regarding the controllability of future outcomes, and 3) significantly alter self-esteem either positively or negatively.[16] Once the attribution process has been engaged, the particular attributions chosen from among the available alternatives will be those that best 1) restore cognitive coherence to the attributor's meaning-belief system, 2) establish a sense of confidence that future outcomes will be satisfactory and/or controllable, and 3) minimize threats to self-esteem and maximize

---

[15]Bernard Spilka, Phillip Shaver and Lee A. Kirkpatrick, "A General Attribution Theory for the Psychology of Religion," Journal for the Scientific Study of Religion 24 (1985): 3.

[16]Ibid., 6.

the capacity for self-enhancement.[17] The degree to which a potential attribution will be perceived as satisfactory (and hence, likely to be chosen) will vary as a function of 1) characteristics of the attributor, 2) the context in which the attribution is made, 3) characteristics of the event being explained, and 4) the context of the event being explained.[18]

The theory behind general attribution offers us a close scientific parallel to the relational and meaning-making context of suffering and human searches for understanding presented by Maes. Attributional characteristics and processes offer us a solid framework out of which to understand our need as human beings to make sense of our existence, especially with regard to contexts and life experiences such as suffering. As terminal suffering is most intense when we are unable to locate this experience within a meaningful context, an application of attribution theory to the experience of suffering within terminal illness will hopefully provide more insight into the centrality of meaning in suffering and pain.

Attribution Theory and Terminal Illness

This notion of attribution theory becomes increasing-

---

[17]Ibid.

[18]Ibid.

ly interesting when we turn to our discussion of suffering and terminal illness. For individuals experiencing tremendous suffering such as through the diagnosis of a terminal disease, a search for causal attribution in their search for meaning and context would provide them with a sense of control and possibly an acceptable reason for what happened, and thus, might also provide them with some basis for optimism.[19]

Social psychologists, and more recently, the medical field, have become increasingly interested in how individuals adjust to sudden, unexpected, and/or negative events in their environment.[20] How people psychologically adjust to a chronic illness has been of interest in recent studies.[21] The research findings suggest that causal beliefs of ill

---

[19]Lea Baider and Moshe Sarell, "Perceptions of Causal Explanations of Israeli Women with Breast Cancer Concerning Their Illness: The Effects of Ethnicity and Religiosity," Psychotherapy and Psychosomatics 39 (1983): 139.

[20]Taylor, Lichtman, and Wood, "Attributions, Beliefs About Control and Adjustment to Breast Cancer," 489.

[21]T.C. Burish and L.A. Bradley, Coping with Chronic Illness: Research and Applications. (New York: Academic Press, 1983); and B.J. Felton and T.A. Revenson, "Coping with Chronic Illness: A Study of Illness Controllability and the Influence of Coping Strategies on Psychological Adjustment," Journal of Consulting and Clinical Psychology 52 (1984): 343-53; D. Reid, "Participating Control and the Chronic Illness Adjustment Process," in H. Lefcourt, ed., Research with the Locus of Control Construct: Extensions and Limitations 3. (New York: Academic Press, 1984): 361-69; and Taylor et al., "Attributions, Beliefs About Control, and Adjustment to Breast Cancer."

patients play an important role in coping and adjusting to a large variety of illnesses.[22]

I have mentioned above that the perception and meaning of a problem situation are among the vital determinates which affects the coping responses of individuals. With this in mind, we can make the assumption that in the case of severe illness, the perception of causation by the patient and his or her family is of key relevance, since this may influence the steps which an individual may take in obtaining treatment, in follow-through with physician advice and the medical regimen, and in participation in a program of rehabilitation.[23] Consequently, an individual's perception of his or her illness and its etiology play a crucial role in the treatment outcome, particularly in the case of terminal illness.

There has been a significant amount of research recently on patient perceptions of their illness and the frequency with which patients engage in a causal search with regard to the etiology and outcome of their illness. There is ample evidence from this research that seriously ill

---

[22]Ajit K. Dalal and Atul K. Singh, "Role of Causal and Recovery Beliefs in the Psychological Adjustment to a Chronic Disease," Psychology and Health 6 (February 1992): 193.

[23]Meni Koslowsky, Sydney H. Croog and Lawrence La Voie, "Perceptions of the Etiology of Illness: Causal Attributions in a Heart Patient Population," Perceptual and Motor Skills 47 (1978): 475.

people form theories about the causes of their illnesses. For example, Taylor, et al., in a study of breast cancer patients, found that 95% of the patients had formed a causal theory.[24] Patients may blame themselves for their illness (e.g., poor diet, stressful life-style) or may attribute the cause to factors beyond their control (bad luck, germs). Linn, Linn, and Stein studied causes attributed to cancer by individuals with and without the disease and concluded that most cancer patients search for an explanation for their cancer.[25]

Timko and Janoff-Bulman have hypothesized from interviews with 42 breast cancer patients that victims' causal attributions for cancer would influence adjustment to the extent that the attributions contributed to or detracted from perceived invulnerability. They have concluded that causal attributions may play an important role in enabling a victim to re-establish a sense of safety and freedom from danger (i.e., a perception of relative invulnerability).[26]

---

[24]Taylor, Lichtman, and Wood, "Attributions, Beliefs About Control and Adjustment to Breast Cancer," 490.

[25]Barbara J. Lowery, Barbara S. Jacobsen, and Joseph DuCette, "Causal Attribution, Control, and Adjustment to Breast Cancer," Journal of Psychosocial Oncology 10 (1993): 39; M. Linn, B. Linn, and S. Stein, "Beliefs About Causes of Cancer in Cancer Patients," Social Science and Medicine 16 (1982): 835-39.

[26]Christine Timko and Ronnie Janoff-Bulman, "Attributions, Vulnerability, and Psychological Adjustment: The Case of Breast Cancer," Health Psychology 4 (1985): 524.

This recent swell in research regarding terminal illness and causal attributions has led one researcher to conclude that patients' causal attributions for their illnesses "constitute an ubiquitous framework within which medicine has to be practiced."[27] The traditional medical model for illness in which patients were deemed to be neither responsible for their illness or their recovery[28] paid little attention to patients' attributions.[29] However, as the attributions of causation made by the ill patient and his or her family have been shown to be of great significance as attempts at regaining control and a sense of safety and freedom, it seems of vital import that medical practitioners and psychotherapists become increasingly attentive to the causal attributions that patients make regarding their illnesses.[30]

Attribution Theory for the Psychology of Religion

It is a given that causal explanation is a hallmark

---

[27]Mary T. Westbrook and Lena A. Nordholm, "Reactions to Patients' Self- or Chance-Blaming Attributions for Illnesses Having Varying Life-Style Involvement," Journal for Applied Social Psychology 16 (1985): 428; F.N. Watts, "Attributional Aspects of Medicine," in C. Antaki and C. Brewin, eds., Attributions and Psychological Change. (London: Academic Press, 1982): 151.

[28]P. Brickman et al., "Models of Helping and Coping," American Psychologist 37 (1982): 368-84.

[29]Westbrook and Nordholm, "Reactions to Patients'," 429.

[30]Ibid., 443.

of religion. Throughout history, scriptures and theologies explain how the world was created, why human beings occupy a special place in the scheme of things, why seasonal changes and natural disasters occur, reasons for success and failure, and why human beings suffer and eventually die. Consequently, an obvious task for the psychology of religion is to categorize the ways in which ordinary people use religious explanations in their search for meaning.[31] I have gathered data on the psychology of religion and will present this information here. I will then superimpose this information on religious attribution on theodicy and human suffering.

In 1975 Proudfoot and Shaver introduced attribution theory to the psychology of religion. They proposed that attribution theory provides a means of understanding the situation in which an individual concludes that an experience has supernatural origins.[32] They suggest that attribution of internal states to divine intervention may be an important component of religious mystical experiences, and that general attribution theory has much insight to share with religious concepts and experience of the divine.

---

[31]Spilka, Shaver and Kirkpatrick, "A General Attribution Theory for the Psychology of Religion," 1.

[32]Wayne Proudfoot and Phillip Shaver, "Attribution Theory and the Psychology of Religion" Journal for the Scientific Study of Religion 14 (1975): 317.

It is now quite common for researchers to draw upon the methods and concepts of attribution process to understand aspects of the psychology of religion. Spilka, Shaver, and Kirkpatrick have offered a systematic attempt to draw on attribution theory and present a formal and extensive framework for understanding God attributions. Integrating existing theoretical efforts and organizing them into a formal attribution theory for the psychology of religion, they have outlined that attributions are relevant to the satisfaction of three basic needs, that of: 1) imposing meaning on events, 2) self-esteem, and 3) of the feeling that one has some control over one's outcomes.[33]

This research on attribution theory as applied to the psychology of religion offers insight into how faith and religiosity play significant roles in individual and familial attempts to understand and make sense out of the experience of terminal suffering. It provides a framework for understanding how faith forms and shapes meaning, enhances self-esteem, and feelings of control for those that turn to religion or their belief system for answers to the questions of this life.

Systems of religious concepts offer individuals a

---

[33]Mansur Lalljee, Laurence B. Brown, and Dennis Hilton, "The Relationships Between Images of God, Explanations for Failure to Do One's Duty to God, and Invoking God's Agency," Journal of Psychology and Theology 18 (1990): 166.

range of procedures for enhancing self-esteem and feelings of control through personal faith, prayer and rituals, as well as a variety of meaning-enhancing explanations of events in terms of God, sin, salvation, etc.[34] They provide individuals with a comprehensive, integrated meaning-belief system that is well adapted to accommodate and explain events in the world.

Spilka states that these systems of religious concepts satisfy the individual's need or desire to predict and control events, either through mechanisms for directly influencing future outcomes or through suspension or relinquishing of the need for direct control. They offer individuals a variety of means for the maintenance and enhancement of self-esteem, including unconditional positive regard, conditional positive regard, and opportunities for spiritual growth and development.

The likelihood of choosing a religious rather than a non-religious attribution for a particular experience or event is determined in part by dispositional characteristics of the attributor such as 1) the relative availability to that person of religious and naturalistic meaning-belief systems, 2) beliefs about the relative efficacy of religious and naturalistic mechanisms for controlling events, and 3)

---

[34]Spilka, Shaver and Kirkpatrick, "A General Attribution Theory for the Psychology of Religion," 7.

the relative importance of religious and naturalistic sources of self-esteem.[35]

The realm of health-related situations is particularly significant for the study of religious attributions. Terminal illness, for example, presents a particular challenge for individuals and their families for the need to find justice, meaning and control in life. Pargament and Hahn studied the various ways that attributions to God are integrated into attempts to maintain meaningful views of the world. They examined the religious response of college students to four types of imagined life events: positive, negative, just world and unjust world. They found that unjust world events were more likely to trigger attributions to God's will than just world events. Positive outcome events were attributed most often to God's love. Negative outcome events triggered attributions to God's anger.[36] Their study demonstrates the important function that attributions to God serve in helping people to maintain a belief in a just world and their coping process.[37]

They found that people were significantly more likely to turn to God for help in negative outcome situations than in positive outcome situations. When personal control is

---

[35]Ibid., 11.

[36]Pargament et al., "God Help Me," 796.

[37]Pargament and Hahn, "God and the Just World," 205.

not feasible or likely to be effective, as is the case with major medical injuries or illnesses, people seek help and understanding elsewhere. From this perspective, God clearly represents one source of reassurance, support, and encouragement that people will be able to endure their stresses.

Their study revealed that attributions to God's will, God's love and God's anger were greater in situations which were unjust, positive outcome, and which had a negative outcome respectively. Attributions to God's will appeared to represent a benign, external, alternative explanation to chance attribution.[38] Their results support the view that people turn to God for help in coping more commonly as a source of support during stress than as a moral guide or as an antidote to an unjust world.[39]

Lerner has theorized that we try to maintain a belief in the world as a fair place where people get what they deserve. However, many health-related situations may challenge the belief in a just world. Self-blame or blame of others offers one means of holding a just world view in the face of suffering. In addition, the prevalence of attributions to God in health-related situations suggest that religious beliefs may provide another framework for under-

---

[38]Ibid., 193.

[39]Ibid.

standing and dealing with these challenges.[40]

Attributions to God contribute to the manner in which people cope with as well as understand health-related situations.[41] Bulman and Wortman studied the reactions of 29 victims of spinal cord injuries resulting in paraplegia. The most common responses to the question "Why me?" were religious, with the accident viewed as part of God's will for the individual.[42] Pargament and Sullivan found that in several health-related situations, causal attributions to God were greater than any other source including oneself.

A number of studies report that parents of childhood cancer victims have noted that mothers and fathers engage in a "search for meaning" in order to understand their child's illness.[43] Parents are resistent to labeling the cause of their child's illness as unknown, and therefore, turn to other interpretations to construct appropriate explana-

---

[40]Ibid.

[41]Ibid., 196.

[42]J. Bulman and C. Wortman, "Attributions of Blame and Coping in the "Real World": Severe Accident Victims React to their Lot," Journal of Personality and Social Psychology 46 (1977): 877-91; Pargament et al., "God Help Me," 794.

[43]Stanford B. Friedman, Paul Chodoff, John W. Mason and David A. Hamburg, "Behavioral Observations on Parents Anticipating the Death of a Child," Pediatrics 32: 610-25.

tions.[44] Friedman et al. studied the attribution of meaning for 46 parents of children who were being treated for cancer. The research revealed that most parents found their beliefs helpful and comforting. They found that although few parents thought about their child's illness in primarily religious terms, some parents did view the illness mainly in religious terms.

This latter group tended to define the illness as the result of God's will and believed that the purposes of a supreme deity could not be apparent to human beings in this life. Although a strong belief system made the illness more understandable, the researchers noted that some of the deeply religious parents were led to question their faith when religious explanations failed to provide the comfort parents had anticipated.[45] Consequently, for those with a

> strong faith religion may act as a double-edged sword. On the one hand, it provides an explanation for the suffering and the loss. On the other hand, it may provoke religious guilt when parents find the proffered explanation does not provide the comfort they had expected.[46]

---

[44]Judith A. Cook and Dale W. Wimberley, "If I Should Die Before I Wake: Religious Commitment and Adjustment to the Death of a Child," Journal for the Scientific Study of Religion 22 (1983): 225; see also Alfred G. Knudson and Joseph M. Natterson, "Participation of Parents in the Care of their Fatally Ill Children," Pediatrics 26 (1960): 482-90.

[45]Friedman, Chodoff, Mason and Hamburg, "Behavioral Observations."

[46]Cook and Wimberley, "If I Should Die Before I Wake," 225.

People may differ markedly in their attribution of causality to God, depending on their conceptions of God and of God's relationship to the effect under consideration. Ritzema has found that the tendency to invoke supernatural explanations was positively correlated with other measures of religious belief and practice.[47] The determinants of the decision to use a supernatural explanation would include general beliefs about the abilities and inclinations about supernatural agents, general beliefs about the nature and limitations of natural causal processes and specific beliefs about the effects under consideration.[48] His study indicates strongly that there are individual and familial differences in the tendency to attribute causality to divine intervention, that this tendency is related to other aspects of religious belief and practice, and that the characteristics of the event affect the degree of attribution to divine causes.[49]

I have presented the theory behind religious attribution in order to provide some insight into the process of incorporating religious beliefs and images of God into our search for meaning, and to highlight the centrality of the

---

[47]Robert J. Ritzema, "Attribution to Supernatural Causation: An Important Component of Religious Commitment?" Journal of Psychology and Theology 7 (Winter 1979): 286.

[48]Ibid., 287.

[49]Ibid., 292.

need for understanding suffering within this framework. As the experience of suffering is most intense when it cannot be located within a meaningful context, general attribution theory offers a scientific backdrop through which to view personal and familial attempts at uncovering new meaning within their faith context. At this point, I will move on to further incorporate this understanding of religious attributions in our discussion of the search for meaning in relation to the experience of pain and suffering by examining the concept that individuals and families have of the nature of God.

The God Question: Theodicy and Supernatural Attribution

It should be stated at the outset that I approach this discussion from the theological tradition of Roman Catholicism. Although this examination is purely Christian in its approach, it should be noted that the tendency to direct anger and blame toward God is not exclusively Christian! For those outside of the Christian tradition, I believe that there are still attempts made toward framing their experiencing within a larger context. It is my hope that this thesis will provide insight into any person's relationship with their God or their Ultimate Context.

The search for meaning and understanding within religious traditions can be traced throughout history. The indigenous healing practices of the east emphasize super-

natural causality, including punishment from sorcery, spirit or God.[50] In addition, the idea of illness as a punishment for individual behavior can be seen throughout literature and history. Greek mythology and biblical lore are full of the notion of plagues, paralysis, and blindness. Disease is justly deserved by the sinner, according to the judgment of some higher power.[51] How individuals, families, and communities view illness and suffering has been greatly shaped by the theological, religious traditions out of which they have emerged, and it is vitally important that this tradition always be reflected back on and integrated into the process of coping with suffering and illness as well as integrating the new understandings which arise as a result.

We have seen above that human beings have an innate desire to seek out understanding and meaning for circumstances and events which shape and form their lives. The attitudes which people hold regarding illness evidence a significant subconscious need to find or create meaningful understandings of the nature, purpose and role of our

---

[50]Ajit K. Dalal and Atul K. Singh, "Role of Causal and Recovery Beliefs in the Psychological Adjustment to a Chronic Disease," Psychology and Health 6 (February 1992): 194.

[51]Jessie C. Gruman and Richard P. Sloan, "Disease as Justice: Perceptions of the Victims of Physical Illness," Basic and Applied Social Psychology 4 (1983): 39.

experiences of pain.[52] For individuals who have faith and belief in God, the creation of these meaning contexts of the role and function of pain and suffering are shaped and informed by their understanding of the nature of God.

Although research in religious attribution has generally focused on God as a single dimension, there is considerable research similar to Ritzema's which indicate that people hold different concepts of God. Most of the research indicates that there are systematic relationships between a person's concept of God and the way in which God is invoked as an explanation.[53] Cook and Wimberley, for example, interviewed 145 parents whose children had died of cancer or blood disorders. They found that the explanations parents had developed to understand the deaths of their children encompassed different views of God. These include an angry punishing God, a deity working toward a greater purpose, and a loving, rewarding, protecting God.[54]

This information necessitates that any exploration of attributions to God must first explore the various understandings of the nature of God which individuals making the

---

[52]J. Harold Ellens, "Toward a Theology of Illness," in Journal of Psychology and Christianity 3 (Winter 1984): 62.

[53]Lalljee, Brown and Hilton, "The Relationships Between Images of God," 1671.

[54]Cook and Wimberley, "If I Should Die Before I Wake"; Pargament and Hahn, "God and the Just World," 194.

attributions hold. Our exploration of attributions has been in the area of suffering and terminal illness, under the guided assumption that human beings have a deep need to find meaning in all things, especially in pain and suffering. In theological arenas, discussions concerning the need to locate understanding and meaning in light of religious faith and to reconcile the evils of this world with that faith fall under the rubric of **theodicy**.

Classical definitions of theodicy requires the adherent of a theistic faith to reconcile the existence of an omnipotent, omniscient and morally perfect God with the existence of evil and suffering.[55] In other words, the purpose of a theodicy is to justify the ways of God to human beings by rationalizing the occurrence of particular evils and human suffering.[56]

Discussions of theodicy are found in arguments around the areas of the problem of human suffering, and divine compassion and the problem of evil, and are, for the most part, quite complex. For the purpose of this investigation, I have chosen to present the argument of the Greek philosopher Epicurus (324-270 B.C), for I have found his presentation of the dilemma of reconciling the existence of God with

---

[55]Kenneth Surin, "Theodicy?" Harvard Theological Review 76 (1983): 225.

[56]Henry Schuurman, "The Concept of a Strong Theodicy," Philosophy of Religion 27 (1990): 64.

evil and human suffering to be straight forward and concise.

According to Lactantius, Epicurus formulated the dilemma of God's omnipotence and his love as follows:

> Either God wishes to abolish suffering and cannot; or He can abolish it and does not wish to do so; or He does not wish to abolish it and cannot do so; or He wishes to abolish it and can do so. If He wishes to do so and cannot, He is powerless, which is not proper to God. If he can do so, and does not wish it, He is merciless, which is equally alien to God. If he does not wish to do so and cannot, He is both merciless and powerless, and therefore not God. If He wishes to do so and can - and this is the only thing fitting as far as God is concerned - whence comes evil and why does God not abolish it?[57]

Following Epicurus' line of thought, it is not difficult to understand the complexity inherent in attempts to reconcile an omnipotent God with the reality of suffering. The first scenario suggests that diseases such as cancer are simply the result of being human in this world, and according to this view, there is a God, but God is not in control of everything that happens. Rabbi Harold Kushner incorporates this theodicy in his work When Bad Things Happen to Good People, having watched his son die at age fourteen from the rare disease Progeria. Such a death, he concludes, is simply bad luck, "an inevitable consequence of our being human and being mortal, living in a world of

---

[57]De ira Dei, 13; PL 7, 121; T. Johannes Van Bavel, "Where is God when Human Beings Suffer?" in Jan Lambrecht and Raymond F. Collins, ed., God and Human Suffering (Louvain: Peeters Press, 1990): 140.

inflexible natural laws."[58] This theodicy holds forth an understanding of a God who cannot intervene in the pain and suffering of this world; an understanding which does not view God as omnipotent or powerful.

The second scenario affords God omnipotent power, but renders a picture of God as one who is not opposed to the suffering in this life. In other words, it is insignificant to God that people suffer; God does not care or God cannot be love. This theodicy envelopes an understanding of God as separated from humanity; a separation which affords God power, but dismisses God's intention to remove suffering. In this type of theodicy, individuals and families who understand God as indifferent to the pain of this life may be less likely to invoke God's power and intervention.

The third scenario presented by Epicurus also leaves us with a God who is indifferent to our suffering, but who is also powerless to confront it. Individuals and families whose image of God leads them to construct this theodicy, view God as not only mercilessly separated from their pain, but also powerless and unable to do anything about it.

We are left, finally, with a theodicy which understands God as One who is with us in our pain, yet has the power to alleviate the suffering of this world. These

---

[58]Harold S. Kushner, When Bad Things Happen to Good People. (New York: Avon Books, 1981): 134.

concepts appear to be difficult to reconcile, yet it is precisely this understanding of God which I propose provides us with a theodicy which enables us to move beyond the meaninglessness to a place where our relationship with God can be maintained. Where the previous theodicies do not quite fit in our search for meaning within a religious context, this scenario provides for grace in listening to the silence which may come in our search, and the peace of embracing the mystery of our existence in the gracious hands of a God who suffers with us in our pain.

Given the restrictions of our God-talk imposed by the mere fact that we cannot talk about God outside of the realm of human experience and human language, the above exposé of the four basic theodicies presented by Epicurus are a good example of where most discussions on theodicy and human suffering circulate. A note needs to be made about the fact that contemporary theologians need to be cautious in addressing the God question in light of the problem of suffering and evil, for they must grapple with the cries of those who have experienced the pain of suffering more deeply; those who may be more experientially equipped to deal with such questions which rise from the ashes of the ovens of Auschwitz and bellow from the clouds of Hiroshima.

It is not my intent here to give the final word on the reconciliation of divine omnipotence with the problem of

suffering. Rather, from the Roman Catholic tradition, I am attempting to provide a framework from which to understand the complexity of this concept, and have provided four examples of specific theodicies which may be constructed by individuals and families in the face of great pain, suffering and the reality of death. As stated above, I encorporate the notion of scapegoating God within a theodicy which understands God as omnipotent and good. This does not negate the fact that regardless of which theodicy one might adhere to, the experience of suffering transforms our previous understanding of the nature of God and how we view the world.

Any search for value and meaning in terminal suffering cannot be undertaken apart from the framework of what Maes calls the Ultimate Context.[59] For some of us this Ultimate Context is belief and faith in God. For myself, as a Christian, as well as for others, this faith rests on the presupposition that God is omnipotent and good. It is necessary, however, to note that although this thesis flows from a Christian orientation, there are those who employ other theodicies in their definition of the nature of God, and, therefore, derive different meanings from their Ultimate Context. Suffice it to say that no matter which theodicy we choose to define the nature of our God, the

---

[59]Maes, Suffering, 53ff.

experience of suffering moves us beyond that theodicy; it brings forth movement to a more silent, inclusive view of God, providing a new understanding of suffering, of life, and providing hope in a life beyond the death around which our fears and anger are based.

For those of us that live with an understanding of life that includes spiritual meaning, order and continuity, and a sense of spiritual direction, the concept of suffering seems less overwhelming.[60] This may not always be the case, however, for belief in God may increase our frustrations which arise from unanswered questions and confusing pain, as can be seen from the above exploration of basic logical arguments in theodicy.

Belief in this Ultimate Context is not the end-all in our search for meaning and understanding in this life; it has to be seen in light of personal experience. It can, however, serve as a vantage-point from which to attempt to understand and explain that which we experience as unexplainable. As H.R. Niebuhr states,

> because suffering is the exhibition of the presence in our existence of that which is not under our control, or of the intrusion into our self-legislating existence of an activity operating under another law than ours, it cannot be brought adequately within spheres of teleological or deontological ethics. Yet it is in response to suffering that many and perhaps all men . . define

---

[60]Ibid., 68.

themselves, take on character, develop their ethos.[61]

It is my contention that human suffering cannot be explained apart from this Ultimate Context, for existential and spiritual issues lie at the heart of suffering. This ultimate realm of suffering has the capability of serving as a holding environment for both questions concerning the nature of God and the reality of human experience, and for true growth and nurturance in relation to self, others, the world and with God.

The fact that human beings search for meaning out of and from within their Ultimate Context necessitates that we ask questions about that context. We have gathered that within the Jewish and Christian traditions, God is seen as a personal being, but the qualities attributed to God vary considerably. Jewish and Christian religious belief systems provide theodicies or explanations for personal suffering that offer approaches to how a benevolent, merciful God can allow pain, tragedy and death to occur, but these explanations do not always provide the comfort and reassurance sought through questioning and searching for meaning.[62]

For example, when we turn to the Old Testament for

---

[61]H. R. Niebuhr, The Responsible Self. (New York: Harper and Row, 1963): 60.

[62]Robert Wuthnow, Kevin Christiano and John Kuzlowski, "Religion and Bereavement: A Conceptual Framework," Journal for the Scientific Study of Religion 19 (1980): 408-22.

explanations of suffering we can see three different reactions to the dilemma of human suffering: suffering is punishment for sin (Exod. 20.5), suffering is absurd (Jer. 15.1-9; Ezek. 24.9-14; Deut. 7.1-2; Jos. 10.40; 24.18), and suffering is a source of renewal (Job 14.13-17; 16.18-17.1; 19.21-27). What makes matters more complex is that these reactions not only run parallel to each other, they are also intertwined. This example of the various explanations for human suffering in the Old Testament gives evidence to the fact that our religious context, although providing a base for reflection, can often leave one confused and still at a loss for definitive explanations for the pain and suffering of this life. We are often left at a place where we must embrace the silence which our theodicies render, and let go to a process of growth and movement toward the mystery of meaninglessness.

The importance of understanding the nature of theodicies concerning terminal illness is that "theodicies are likely to have an important bearing on the manner in which individuals cope."[63] Theodicies are a specific and critical instance of general attribution theory as applied to religious attribution. Theodicies provide us with a context within religious attribution, and attribution theory in general, to locate religious attempts to understand human

---

[63]Ibid., 413.

suffering, and to search for an appropriate, effective meaning-making framework out of which to locate understanding in the coping process.

What I am proposing in this discussion of theodicy and causal attribution is the import of a theodicy which understands God as omnipotent and good. Theodicies such as those which I also mentioned above do not provide the occasion for growth and movement through their particular understanding of God to an acceptance of the mystery of their God and of their suffering. A theodicy which sees God as omnipotent and good provides a context which allows for and holds the breakdown of meaning in their suffering, and promotes further personal relationship with God through movement beyond meaninglessness to an embrace of the silence in their struggle.

In addition to understanding the Ultimate Context out of which one formulates understanding in regards to human suffering, it is also significant that religious attributions and personal theodicies are shaped and formulated in light of the different images of God held by individuals and families. For example, Cook and Wimberley sought to relate different images of God, such as the qualities we revealed in our discussion of various theodicies above of God as being unmerciful, punishing, or purposeful, to differences in the conditions under which explanations in terms of God

are likely to be invoked.[64] From research gathered from 145 parents of children who died after being treated for cancer or blood disorders, they then examined the effectiveness of theodicies constructed to explain their child's death. Their research revealed three specific types of bereavement theodicies: 1) reunion with the child in an afterlife; 2) the child's death as serving a noble purpose; 3) the death as punishment for parental wrong-doing. These specific theodicies were constructed by parents to assist them in feeling as though they had some control over their situation, but most importantly, it provided them with a framework out of which to understand the pain and suffering they were experiencing.

Providing a framework for understanding, however, is not the same as the understanding itself. Theodicies provide opportunity for placing our pain and suffering within a context to assist in the understanding. The context which a particular theodicy provides may or may not lend itself to growth and movement through the meaningless-ness. Theodicies are, for the most part, ultimately useful only in the event that they enable the individual to move through their grief to an acknowledgement, acceptance, and acclamation of the mystery of their suffering, and of their

---

[64]Lalljee, Brown and Hilton, "The Relationships Between Images of God," 167.

God. Parents who, for example, chose to see their child's death in light of the reunion with them in an afterlife as part of their bereavement theodicy--a framework used to make sense out of their experience--although theu were able to cope more effectively, they were not able to do away with the pain or meaninglessness and hence, to move beyond it. It is this element of specific theodicies, the fact that they fall short in providing ultimate meaning, which leads me to conclude that what is necessary is a theodicy which sees God as omnipotent and good, allowing us to embrace the mystery of our faith, and of our suffering, providing movement and growth. This theodicy is sort of the theodicy of the breakdown of theodicies; it exemplifies the breakdown of our understanding and provides for immediate personal relationship with a God who suffers with us.

The coping process as effected by the type of theodicies constructed in one's search for meaning is most positively influenced through the use of this type of theodicy which allows for an understanding of God as omnipotent and good, providing for movement through meaninglessness in suffering to further relationship with God in embracing the mystery of our existence and the mystery in our suffering.

Attribution theory and its application to the psychology of religion has provided us with insight into the

characteristics of specific and critical instances of the process of incorporating religious beliefs and images of God into our search for meaning and the centrality of the need for understanding suffering within a framework which offers clarity and hope. It is my hope that the theory behind general attribution has offered us a close scientific parallel to the relational and meaning-making context of suffering and the centrality of meaning in the search for understanding presented by Maes. We have seen that suffering is most intense when we are unable to locate this experience within a meaningful context. Theodicies which incorporate religious attributions offer us a solid framework out of which to understand our need as human beings within an Ultimate Context to make sense of our existence, especially with regard to suffering.

This thesis is concerned with families who employ the first type of theodicy proposed by Wuthnow, that of blaming God for the genesis, course and/or outcome of serious illness and suffering, allowing for movement beyond the pain to acceptance of the mystery in relationship with God. I have defined this form of attribution as the approach which incorporates scapegoating God. In order to explore family theodicies which blame God in the coping process, we must first explore the nature of the family as a **system** and the theoretical approaches which help us to understand the

family as a healthy, functioning unit, as well as how the experience of suffering and terminal illness effects the family's coping process.

CHAPTER 3

FAMILY SYSTEMS AND TERMINAL ILLNESS

I wanted to crawl into her body
and do the pain for her.

My mother

Families with a terminally ill member must make a series of adaptations in the coping process. They must adapt to the patient's treatment, to the uncertainty of crises and death, to changes in patient's functioning and appearance, and to the increased demands of care, all of which must be viewed in light of their own understanding of death and suffering.[1]

Some researchers have postulated that there is a relationship between the meaning that the family ascribes to a stressor, such as terminal illness, and the family's adaptation to it.[2] In addition, the meaning of the terminal illness to family members also has implications for compli-ance with treatment procedures and protocol and,

---

[1]Alberta Koch-Hattem, "Families and Chronic Illness," in David Rosenthal, ed., Family Stress, The Family Therapy Collections. (Rockville, MD: Aspen Publishers, 1987): 33.

[2]R. Hill, Families Under Stress. (New York: Harper and Row, 1949); and H.I. McCubbin and J.M. Patterson, "The Family Stress Process: The Double ABCX Model of Adjustment and Adaptation," in H.I. McCubbin, M.B. Sussman, and J.M. Patterson, ed., Social Stress and the Family. (New York: Haworth Press, 1983).

thus, prognosis.[3] The task of adapting to the illness of a family member is varied according to 1) the nature of the illness and its treatment; 2) the extent to which it disables or threatens the life of the patient; 3) the patient's role(s) in the family; 4) the family's prior experience and/or attitudes about illness; and 5) the family's developmental stage. Consequently, a family's success in adapting to the terminal illness of one of its members depends on its previous level of functioning, its availability to various resources, the meanings it attaches to the illness and resulting chances in the patient and family, and its flexibility in the face of stress and change.[4]

Reflecting on his personal and professional experiences with cancer patients, Wellisch stated that:

> the major emotional problem for the family system confronting cancer is learning to live adrift in an uncharted sea with little concrete knowledge of where this situation will take them, but usually having brutal and punishing fantasies or images of what the future holds. The family must deal with two levels of major problems: unspoken fears and fantasies, and frustrations and emotional drain of real and known aspects of cancer. The real and known aspects become learned when the family attempts to live with these sequelae of chemotherapy, radiation, recurrence, and, finally, the reality of

---

[3]Koch-Hattem, "Families and Chronic Illness," 35.

[4]Ibid.

death.[5]

It is understandable, therefore, that former ways in which the family dealt with interactions, needs, plans, and finances now seem inappropriate, roles are unbalanced, and disequilibrium shakes the entire structure of the system. The stress and upset that the family experiences will have ramifications throughout the family system, causing shifts in the way family members manage conflict, the way they interrelate with one another, their patterns of communication, and the system's method for making decisions.[6]

From this and similar research I have gathered that there is a large body of literature on the psychological and emotional stresses generated in families of severely ill patients. Some of the work focuses on the psychological state of all family members, while others focus on special relationships, such as spouses, parents, children, and siblings of patients in relation to the illness. The majority of the work focuses on (1) the families of pediatric cancer patients, because the central role of the

---

[5]David K. Wellisch, "On Stabilizing Families with an Unstable Illness: Helping Disturbed Families Cope with Cancer," in M.R. Lansky, ed., Family Therapy and Major Psychopathology. (New York: Grune and Stratton, 1981): 290.

[6]For a thorough comparison study of the psychological adjustments of the siblings of children with terminal illness, see John V. Lavigne and Michael Ryan, "Psychologic Adjustment of Siblings of Children with Chronic Illness," *Pediatrics* 63 (April 1979): 616-26.

family has always been obvious in pediatrics, and (2) the problems of bereavement, because death creates a well-defined crisis around which to organize observations.[7] The concentration of attention in these two vastly different areas has provided what I have seen to be an empty crevasse in research where the reactions of family systems to terminal illness should be examined, for how can one study the central role of the family for pediatric patients or the crisis a family experiences as a result of the death of one of its members without first studying the family **system**?

As this thesis is concerned with families who scapegoat God in their attributional search for meaning and context, it would be most helpful to explore the nature of the family as a **system** and the theoretical approaches which help us to understand how the family functions and copes with stress when it is healthy, in addition to how the family reacts and adapts to the experience of suffering and terminal illness.

Just as the above exploration of attribution theory and its application to religious searches for meaning provided us with more insight into the centrality of meaning in the process of seeking understanding in suffering, the

---

[7]Douglas Rait and Marguerite Lederberg, "The Family of the Cancer Patient," in Jimmie Holland and Julia H. Rowland, eds., Handbook of Psychooncology: Psychological Care of the Patient with Cancer. (New York: Oxford University Press, 1989): 586.

following exploration will provide a relational context from which to consider the notion of scapegoating God, in that it will focus on the family as a system, and its reaction to the suffering of terminal illness.

What follows is a conceptual approach to the issue of families and terminal illness, exploring the psychosocial management of families with a terminally ill cancer patient from a **family systems** perspective. It emphasizes an understanding of the family system as facing a series of adaptive tasks in relation to the illness.

I will examine familial patterns of coping and adapting to the unpredictable stress of terminal illness inclusive of the stages of family crisis in conflict management, the effects of the illness on the decision making process within the system, and communication patterns for dealing with terminal illness.

Family Systems Theory

What follows is a brief exploration of two of the most significant approaches to family counseling. This review is not intended to be instructive of the theories of family counseling. Rather, I have chosen to elaborate on a few of the **systems** theories which are able to be integrated effectively in dealing with families experiencing the crisis of terminal illness. I have found a systems approach to looking at the family as a whole to be helpful in providing

a basis for examining the individual members as well as to be able to gather insight from how the individual family members function together as a whole.

It is important, at the outset, to understand what is meant by the term **system**. The concept of system when applied to the family means the sum of the interrelated and interconnected members who have mutual causality and accountability which form the whole family unit. A family is an open system, having a continual flow or open to change.

Murray Bowen developed Systems Family Therapy as a result of his work with schizophrenic clients and their families. Viewing the family as a system, he believes that individuals within the system do not function independently and that change in the individual would affect the system just as change in the system would affect the individual family members. Concepts such as differentiation of self, intergenerational transmission process, birth order and sibling position, family triangles, family projection process, and emotional cutoff are concepts which are integral to a Bowenian or Intergenerational Family Systems Therapy.

This form of therapy attempts to center its clients on gathering information and understanding about their system through genograms, family interviews and exploration.

Admittedly, Intergenerational Family Therapy is best suited for families which are not in an immediate crisis and who have the time, energy, finances and desire to undertake an often lengthy exploration of their system. However, I do believe that this approach provides a useful means of conceptualizing family functioning, and provides key insight into the patterns of understanding and meaning, as well as how specific theodicies as transmitted intergenerationally.[8]

Salvador Minuchin is the primary developer of the Structural Family Therapy approach. The goal is to change the structure of the alliances and the coalitions of family members, and by doing so, to change the family's experiences of one another. Minuchin advocated taking an active approach to family counseling, having the therapist join the system and use himself or herself to transform it. By changing the position of the system's members, the therapist changes their subjective experiences.[9]

Minuchin moves away from looking at past experiences with major concern for the present, the here and now of family structure, which is optimal when dealing with the crisis of terminal suffering as it effects the family in

---

[8]Linda Seligman, Diagnosis and Treatment Planning in Counseling. (New York: Human Sciences Press, 1986): 255.

[9]Salvador Minuchin, Families and Family Therapy. (Cambridge, MA: Harvard University Press, 1974): 14.

their present functioning. Structural Family Therapy focuses on concepts such as family structure, subsystems, subsystem boundaries, and adaptation to stress. He focuses on the ongoing interactions in the family which tend to reinforce existing behavior. He sees the family organization as posing the problem in family maladjustment, in that it needs the symptomatic member for its continued functioning.[10]

I have briefly explored the family systems approach to family therapy of Murray Bowen and Salvador Minuchin. I take an eclectic approach to family systems therapy in that I incorporate both approaches in this discussion of family systems and terminal illness. I believe that treatment planning for families is a complex process and needs to be flexible in assessing family dynamics and integrating information with the skills of the counselor and individual family members to determine the most effective approach to take with individual families. What follows, therefore, will be an integrative approach to family systems therapy and assessment in dealing with the system experiencing terminal illness.

Through the integration of these two theoretical approaches to family systems theory, I understand a healthy,

---

[10]Raymond Corsini, ed., Encyclopedia of Psychology, 2cd ed., s.v. "Family Systems," (New York: John Wiley and Sons, 1994).

functioning family system as one which is effective and competent in raising autonomous children, and one where the parental marriage espouses shared power, open communication and shared feelings. The family unit is characterized by closeness and individuality, open patterns of communication, early identification of problems and implementation of efforts to alleviate conflict through reliance on negotiation as an important approach to problem-solving. In addition, individuals in healthy family systems rely on rationality and feelings, not on authoritarian rule systems to support their basic value judgments.

Healthy family systems emphasize clear roles, shared power, effective problem-solving, openness with feelings, and acceptance of individual differences. The essential tasks of the healthy family system are stabilization or encouragement of growth in the parents' personalities and the production of autonomous children. The essential characteristics of its individual members, and therefore, hallmarks of the system itself are the ability to love, work and play, the capacity to deal effectively with unpredictable stress, and the ability to master the stages of life. In light of terminal illness and the experience of suffering, I understand the healthy family system as facing a series of adaptive tasks in relation to the illness. Consequently, I will examine crucial areas where familial

patterns of coping and adapting are necessary, such as handling stress, decision-making, and communication.

Crisis and Stress in the Family

We have seen from the earlier discussion on the centrality of meaning in terminal suffering that what is crucial is for individuals and their families to find a context out of which to understand their experience. In the experience of terminal suffering, it is precisely the **crisis** which the family is experiencing that provides the opportunity for gathering new meaning. The crisis provides for an emptying of self which allows for community. It moves people beyond a certain way of looking at life to a new way of relating with one another and with God.

Not every stressful situation experienced by a family unit results in crisis. As Jerry Lewis has outlined, there are several important aspects of stress which can help to evaluate its severity. The first concerns whether it is acute or chronic. Second, whether the source of the stress is internal or external to the family unit. The third aspect of family stress involves whether something concrete can be done to alleviate it.[11] In addition, Reuben Hill suggests that there are three variables which specifically

---

[11]Jerry M. Lewis, How's Your Family? A Guide to Identifying Your Family's Strengths and Weaknesses. (New York: Brunner/Mazel, 1989): 132-33.

determine whether stress will result in a crisis for the family: (1) the hardships of the situation or the event itself; (2) the resources of the family; and (3) the definition the family makes of the event; that is whether members treat the event as if it were or as if it were not a threat to their status, goals, and objectives.[12] Therefore, we can conclude that the basis for a family crisis is:

> the situation cannot be easily handled by the family's commonly used problem-solving mechanisms, but forces the employment of novel patterns. These are necessarily within the range of the family's capacities, but may be patterns never called into operation in the past.[13]

Concerning the stress of illness in particular on the family unit, it has been suggested that factors which influence the family's adjustment to the illness are (1) the overall competence of the family; (2) the family role of the sick person; (3) the seriousness of the illness; (4) the communal, extrafamilial support system of the family; and (5) the sick individual's personal response to the illness.[14] These factors give evidence to the fact

---

[12]Quoted in *Families in Crisis*, Paul H. Glasser and Lois N. Glasser, eds. (New York: Harper and Row, 1970): 7.

[13]Howard J. Parad and Gerard Caplan, "A Framework for Studying Families in Crisis," in *Crisis Intervention: Selected Readings*, ed. by Howard J. Parad. (New York: Family Service Association of America, 1965): 57.

[14]Lewis, How's Your Family?, 151.

that the need to adjust to the diagnosis of terminal illness results in a crisis for a family.

In this crisis, the family system must accomplish certain tasks apart from what the individual family members must accomplish, although these two processes proceed simultaneously. Thus, a major feature surrounding terminal illness as a crisis is that its effects can be seen on two levels; the intrapsychic and the intrafamilial.[15] We must always be cognizant of the intrapsychic adjustment of each individual as well and the effect this has on the family system as a whole, and on the relationships which the family has with each other, with the community and with God.

Van Dongen-Melman, in his work prescribing a conceptual framework for studying the impact of childhood cancer on the psychological and social functioning of the child and the family, proposes that a stimulus is perceived as a stressor when it causes (1) uncertainty, (2) loss of control, (3) threat to self-esteem, and (4) negative feelings. These four aspects of stress can vary in intensity and can occur simultaneously.[16] When the patient and his or her family are confronted with these stressors,

---

[15]Stanley B. Goldberg, "Family Tasks and Reactions in the Crisis of Death," Social Casework (July 1973): 399.

[16]J.E.W.M. Van Dongen-Melman et al., "Coping with Childhood Cancer: A Conceptual View," Journal of Psychosocial Oncology 4 (Spring/Summer 1986): 149.

the family system is motivated to use coping strategies to lessen or eliminate these stressors. They will employ strategies such as seeking information, seeking support and comfort, attributing events to causes, attempting to change the situation, using denial and avoidance, and accepting the situation.[17] Most of these strategies have been discussed at great length in related literature on coping with stress.

If we recall our earlier discussion about attribution theory, we can now see its import in relation to the coping strategies used by the family system in order to maintain balance in the face of the crisis of terminal illness. Part of the coping process for individuals and families is to attribute events to certain causes, and within their Ultimate Context, they will construct certain theodicies from which to understand their experience of suffering. We know from the discussion above that a search for causal attribution provides them with a sense of control, an acceptable reason for what happened, and also provides them with some basis for optimism. It is evident here that the strategies used by families in their coping with terminal illness, such as the search for causal attribution, are crucial, for the meaning and understanding that a family derives both from its search and from the meaning of

---

[17]Ibid., 152.

suffering and death passed down intergenerationally, have significant ramifications in the functioning of the family unit as well as the prognosis of the individual member who is ill. We have seen how the specific theodicy which families use in their search for context and understanding is most helpful if it views God as omnipotent and good, and how this understanding allows the family to move beyond the meaninglessness for more intimate connection with each other and with God in their suffering. With this understanding of crisis and stress in the family, I will move on to discuss patterns of coping and adaptation involved in the conflict management and decision-making process within the family system.

Conflict Management and the Decision Making Process

Medical social work research in the past has relied upon a psychoanalytic base for understanding the behavior of an individual faced with terminal illness. Individuals and their families were assessed with the language of defense mechanisms such as regression, denial, and dependency, rather than in terms of coping and adaptation. While these defenses are important to recognize as attempts to protect the self from ego disorganization under the impact of illness, they should not be the entire focus of an approach to examining individual and familial conflict management

styles.[18] Rather, patterns of adaptation and efforts to deal with the environment and to restructure the life style of the patient and family are vitally important areas to investigate.

Conflict management within the family system concerns the patterns of coping with unpredictable stress brought on by the sudden diagnosis of terminal illness. It is important to understand the family structure at the outset, for when a family copes with impending death or with the sudden diagnosis of terminal illness, it will first turn to its customary style of coping and problem-solving to deal with the stress. Therefore, it is imperative that family systems therapy look to the usual and customary mode of functioning for a family. The diagnosis of terminal illness will initially be an accent on the family's usual mode of functioning.[19]

It is important to remember that the meaning of terminal illness to the individual and to the family changes throughout the course of the disease, and, as a highly variable experience for the family system, has a strong influence on the way in which a family copes with crisis and stress throughout the duration of the illness. Mailick has

---

[18]Mailick, "The Impact of Severe Illness on the Individual and Family," 118.

[19]Cohen, "Living in Limbo," 562.

emphasized coping and adaptation, an approach which encourages a delineation of tasks created by the illness for the individual and the family.[20] The first set of tasks are connected with the onset of the illness, the diagnostic phase; the second phase is associated with adaptation to the long-term or disabling nature of the illness; and the third phase deals with the ending of the illness, either through cure, remission, or death.[21]

Diagnostic Phase

Crisis theory has identified several tasks that the individual and the family must accomplish at the onset of the illness. The first of these is dealing with a period of uncertainty during which the symptoms of the patient have been noted but not diagnosed. Here the patient and the family must handle together and individually the anxiety of not knowing, the fantasies or fears about what may be wrong, the guilt, and the physical and emotional strain of tests.

The family must employ problem-solving mechanisms that have worked in the past for them, and they are successful, as mentioned above, depending upon the severity of the illness, its implication for the future in the patients' and the family members' minds, and the social and communal

---

[20]Mailick, "The Impact of Severe Illness on the Individual and Family," 117-28.

[21]Ibid., 119.

support systems available to them. The diagnosis of terminal illness will often be met by the family systems' initial avoidance of its full and realistic meaning, by employment of tactics of delay, cognitive distortion, and even resignation.[22] How the family reacts to the diagnosis depends on the meaning the system has generationally derived from pain, suffering and death, and this meaning, as well as how open the system is to altering these understandings, is crucial to how well the family will cope during this phase.

A family may attempt to detour around the threat of loss posed by the terminal illness of one of its members by focusing its attention and that of others upon another member. It has been found that children of terminally ill patients, rather than becoming depressed, will usually regress, lose bladder control, become temperamental and draw aggressive pictures, and have school problems in an attempt to redirect energy away from the threat of loss. Adolescents have been shown to have school problems and increased drug abuse in a seemingly unconscious effort to deflect the attention of the family away from the illness and onto their own problems.[23]

---

[22]Ibid., 120.

[23]David K. Wellisch, Michael B. Mosher, and Cheryle Van Scoy, "Management of Family Emotion Stress: Family Group Therapy in a Private Oncology Practice," International Journal of Group Psychotherapy 28 (1978): 230.

The regulation of information and its utilization by the family system is a crucial task of the diagnostic phase. Research has shown that one of the most crucial elements of family satisfaction with medical treatment is their sense of involvement in the decision making process.[24] Denial and acceptance are two complementary processes by which the patient with cancer and his or her family system regulate information in the decision making process, and also in their search for meaning. While the family might begin by denying the diagnosis of malignancy, it might go on to accept the diagnosis, but deny the implications of it.[25] With regard to their search for meaning and constructing theodicies to help in this search, the family may initially deny that God had anything to do with the illness, then move on to embrace the omnipotence of God, but deny that God is also good. This process prevents the paralyzing sense of loss and depression that would be disorganizing to the family system if information were not regulated. It is important to note, however, that the family must eventually integrate the diagnosis, its meaning, its course and its

---

[24]Rait, "The Family of the Cancer Patient," 586.

[25]A. D. Weisman, On Dying and Denying: A Psychiatric Study of Terminality. (New York: Behavioral Publications, 1972).

outcome.[26]

The concept of autonomy is closely related to the regulation of information. The patient must be able to sustain the maximum amount of freedom and autonomy. This raises numerous questions and possible problems within the family system regarding conflict management styles, and how the family adapts to the new roles of each member. For example, problems may arise in the closed family system if the family decides as a unit that they cannot trust the psyche of the patient to take the full burden of the monitoring of information, therefore deciding to regulate information for the patient that might be "too sensitive" or "too stressful."

The decision to exclude the ill family member from the management of conflict within the family is most likely not verbally communicated to the patient, but rather, a mere continuation of the way in which the family communicates and makes decisions. I shall talk more about family patterns of communication in the face of terminal illness later in this investigation.

The third factor influencing adaptive behavior during the diagnostic phase is the maintenance of the internal

---

[26]Mailick, "The Impact of Severe Illness on the Individual and Family," 121.

organization of the individual and the family.[27] The family must perform certain tasks in order to maintain its balance. The blame, guilt, and shame that are sometimes engendered by the illness, as well as the anxiety and depression, must be dealt with. The family may respond by a temporary change in patterns of communication, and their patterns of interaction may become rigid, decrease or increase in number, or lack spontaneity.[28] Family members may become temporarily less productive and creative and may withdraw from contacts with outside social networks. These are all responses by the family to the danger to the family balance. Until the family can reintegrate, adapting to new roles and rela-tionships, "their main efforts are toward survival and the integrity of the family and the individual."[29]

It is important to note here that a temporary breakdown within the family system is not necessarily indicative of family pathology. Family systems can reach a point of emotional recovery and family integration after periods of enormous stress and a seemingly chaotic and fragmented existence. This is dependent on several factors,

---

[27]Ibid.

[28]Ibid.

[29]Ibid., 122.

inclusive of the cushion of emotional and material resources the family system has as its support network. Families which are socially isolated or poverty stricken, structurally inflexible or which have poor patterns of communication and affectual relationships, may have more difficulty. However, these factors are not necessarily predictors of a family's ability to cope and grow as a result of the impact of the diagnosis of terminal illness.

Adaptation Phase

As the diagnostic phase draws to a close, the family must deal with the on-going task of dealing with the terminally ill member. The family needs to evaluate their physical, social, and emotional environment to uncover obstacles which may prevent the individual and the family from coping as normally as possible. This most often requires alterations in interpersonal relationships, intergenerational role expectations, and physical space to allow the greatest amount of cohesion and adaptability.

As the patient must deal with ongoing pain and discomfort, loss of physical control and changes in physical appearance, the family must deal with their feelings in tolerating the patient's suffering, their sense of powerlessness, and their ambivalence, anger, guilt, and fear. Added stress on the family system occurs as they attempt to balance the demands made upon them to rearrange their lives

in order to care for the patient, while at the same time attending to the needs of the other family members to ensure continued growth and stability.

The management of role shifts is important to consider here. For the family there is the delicate balance of managing to take over the functions of the patient without shutting him or her out of the system. For the patient there is the task of accepting the revised role and self-image. The family is an important factor in the patient's ability to adapt to this long-term change in self-image. The family must provide response and feedback that encourages the self-esteem of the patient while reflecting acceptance of him or her as a person in order for healthy coping to exist.[30]

It is often the case that a family will experience intense difficulties in this area, and in order to relieve its internal conflict and stress, the system will diffuse the parental subsystem boundaries to such a degree that anyone is allowed to participate in executive duties.

Role shifts within the family system have an important play on the decision-making process within the system itself and appropriate, mutually accepted and agreed upon role reassignment and assumption is one of the most difficult areas within the family system requiring readjustment.

---

[30]Ibid., 124.

In addition, adaptation to new role reassignment is also necessary with regard to the family's understanding of the nature of God, for it is often the case that the family must reformulate who God is for them in light of the theodicies they construct in their search for meaning. A family who has understood God to be all powerful, may question this image in the face of the suffering it is experiencing. In light of the importance of God image and familial understandings of the nature of God in their search for causal attribution, we can see that it is equally important to consider how the family is adapting to revised divine role assignments.

Ending Phase

The final phase of adaptability may be marked by cure, remission or the death of the family member. The concepts of coping and adaptation concerning death has received more attention than any other stage of illness. Goldberg has outlined the family task of grieving, which includes facilitating the process of mourning for all members, assigning the proper role to the memory of the deceased, reassigning roles and expectations among the remaining members, and establishing new or altered relationships outside of the family.[31] As a side note, I

[31]Stanley Goldberg, "Family Tasks and Reactions in the Crisis of Death," Social Casework 54 (July 1973): 398-405.

agree with Kübler-Ross that the terminal stage of life can also be the final stage of psychological growth for the individual, and can be facilitative of growth within the family system as well. Consequently, an attempt to focus on how the family can work toward maximal intimacy, sharing, and support, as well as deal with the oncoming death and inevitable separation during the terminal period would be a major goal in the therapeutic process.[32]

A diagnosis of terminal illness signals the threatened and eventual loss of a significant relationship for members of a family. Not only may the individual child or adult die, but the daughter-sister, son-brother, wife-mother, or father-husband, "are threatened by the subliminal recognition of the dissolution of the family."[33] It is safe to say that no matter how equitable and explicit the role distributions are within a family system, the number and types of roles held by the terminally ill or deceased member has a direct influence on the difficulty or ease with which the family is able to readjust. The system's loss of instrumental or task-oriented roles such as mother-wife-lover-breadwinner, may present the family with the

---

[32]Elisabeth Kübler-Ross, Death: The Final Stage of Growth. (Englewood Cliffs, NJ: Prentice-Hall, 1975).

[33]Eric Bermann, Scapegoat: The Impact of Death Upon an American Family. (Ann Arbor: University of Michigan Press, 1973): 144.

troublesome and difficult task of reallocating numerous roles, many of which may have been exclusive to the ill or deceased member.

It is fair to say, therefore, that upon the death of a family member, the single most important factor in the reorganization of the family as a continuing social system, is the family's readjustment to the role the descendent had been assigned, and which he or she assumed within the family system.[34]

In healthy family systems, the resumption of adaptive functioning after the death of a family member is facilitated and supported, for vital roles and functions "have been apportioned among members in a just and equitable manner for optimal comfort and satisfaction in their performance."[35] Optimal apportionment is achieved when roles are reassigned and assumed according to individual need, ability and potential. With this type of functioning, the critical reorganization period is less likely to be experienced as a crisis because the family already has an internal process which allows it to reallocate and reassign the role functions of the ill or deceased member with

---

[34]Rita Vollman, Amy Ganzert, Lewis Picher, and W. Vail Williams, "The Reactions of Family Systems to Sudden and Unexpected Death," in *Omega* Vol. 2 (1971), p. 104.

[35]Ibid., 104.

minimal difficulty.[36]

If the death of a family member resulted from a long illness, siblings and parents may feel a sense of relief that the other's suffering has ended. This relief, however, brings with it guilt for having wished for the end or for impatience with the ill family member during the course of the illness. The death of the family member brings grief, sorrow, and loneliness, no matter how much the family as a unit may have suffered as well. These reactions of family members are crucial when we consider how they influence the shape of the theodicies constructed in order to explain the suffering. Attributions to God are shaped by the feelings of anger, shame, guilt, and loss we experience in the suffering. In other words, the guilt one may feel for having wished for the end, may be turned into anger at God for allowing the death to occur. Here we can see ho the family's attributional search for meaning is influences and shaped by how the family understanding suffering and death, and how the family adapts to the new meanings imposed by the suffering.

Sibling reactions to the death of a child in the family often go unacknowledged and unrecognized, as the monumental grief of the parents overshadows all other feeling in the family. In this scenario, siblings find

---

[36]Ibid.

themselves in the role of having to comfort their parents, being their pillars of strength.[37]

Further difficulties result if the individual, symptomatic family member's illness results in death and there may be additional problems which the family system will have to face as well. For example, if the individual performed the crucial role of symbolizing and representing a disturbance in the family system, the maintenance of the entire family structure may be in jeopardy. The death of that individual sets off a process in the family which is parallel to symptom substitution in the individual.[38]

Symptom substitution can be defined as "the replacement of one set of behaviors, thought to express or represent some inner conflict, by another set whose function is identical."[39] This occurs when the inner conflict is not resolved, but the external representation of it in behavioral form no longer exists.

The family system mirrors a similar process. Many therapists have documented the development of symptoms in one family member when those of another family member have

---

[37]Francine Klagsbrun, Mixed Feelings: Love, Hate, Rivalry, and Reconciliation Among Brothers and Sisters. (New York: Bantom, 1992): 243.

[38]Ibid., 105.

[39]Ibid.

shown remission during the course of treatment. When this symptomatic family member dies, however, the family system undergoes the difficult task of redistributing his or her task. This individual's family system is now faced with a painful readjustment period, and if it is unsuccessful in reassigning the role or in working through the original system's underlying conflict, the system faces the threat of collapse.[40]

The less obvious effects of terminal illness on the family system which does function adequately with regard to conflict management, is the further impact of illness on the health of the other family members. In families with a terminally ill member, the incidence of illness in a second family member is higher than would be expected by chance.[41] Another family member may develop the symptoms of the ill member, and children often complain of symptoms of the ill parent. Spouses complain of increased interpersonal tension and symptoms which correlated with tension levels and symptoms of the terminally ill patient.[42] Thus, family members are forced to respond to both the stress within the

---

[40]Ibid.

[41]J.G. Bruhn, "Effects of Chronic Illness on the Family," Journal of Family Practice 4 (1977): 1058.

[42]R. F. Klein, A. Dean., and M.D. Bogdonoff, "The Impact of Illness Upon the Spouse," Journal of Chronic Disease 20 (1976): 241.

system of a terminally ill member and to already developed symptoms in others.[43]

During this end phase a different set of tasks is required for the family to negotiate if the illness results in a remission. This requires the family members to balance opposing emotional tasks. Expectations of both the family member who was ill and the family itself must again be altered, roles reassigned, and new balance established.[44] In addition, "remission" is retrospective in that only at the end of a remission will there be certainty of a "cure." Therefore, the family must deal with the added task of coping with the uncertainty and must regulate its hopefulness. Healthy balancing needed for normal functioning requires that all family members incorporate a sense of hope for a complete cure with the recognition of further possible episodes of illness.[45]

During a remission, therefore, the family has the task of balancing its image of the patient as presently well with possibly being ill again in the future. The family must allow the patient back into its midst, facilitating the

---

[43]Janet Christie-Seely, ed., Working with the Family in Primary Care: A Systems Approach to Health and Illness. (New York: Praeger, 1984): 149.

[44]Mailick, "The Impact of Severe Illness on the Individual and Family," 125.

[45]Ibid., 126.

reacquisition of as many of the old roles and responsibilities by the patient as possible. This time of transition and readjustment may be very difficult and stressful for the family system, for the family may have learned a new way of functioning without the patient, and some members may be reluctant to relinquish their new roles.[46] If the family has done extensive grief work and has accomplished the task of working through the eventual loss of the patient, it may be difficult for the system to then connect with him or her except as a sick person.

It is during a remission that the family will have to deal with post-illness conflict management. For example, under the stress of illness, personal animosities, angers, and disappointments may go unexpressed by family members. However, during a remission, these feelings are reactivated. The family system must deal with the conflictual paradox that just when things were getting better, they have to face an increase in hostility toward each other. A flexible family structure can allow for conflict and the expression of anger as well as the redevelopment of positive, appropriate affect toward the patient. Family systems with rigid structures may need for the patient to be sick indefinitely, in order for the repressed conflict and anger to remain covered.

---

[46]Ibid.

Joseph Frey has done extensive research on the illness-maintaining behaviors within the family system.[47] For a time following the diagnosis of terminal illness, it is typical for the patient and the illness to be center-stage within the family. This process organizes the family, underscores the serious nature of the medical problem, and encourages the development of new health care management behaviors within the patient and the family system. To truly adjust, however, the centrality of the illness must only be temporary.

This central positioning of the illness in the family necessitates that other family problems be neglected for a time. If these problems had been particularly hurtful or threatening to the family's structure, the illness may remain central in the family permanently. When this happens, the illness becomes the overriding family issue around which the members organize as the resolution of other transitional issues is delayed indefinitely. Illness-maintaining behaviors keep the illness and the patient as the family's central, defining characteristic. This behavior will surface in problems with boundaries and subsystems and will affect marital, parental, and sibling

---

[47]Joseph Frey, "A Family/Systems Approach to Illness-Maintaining Behaviors in Chronically Ill Adolescents," Family Process 23 (June 1984): 251-60.

relationships.[48]

For example, spouses who have failed to deal with marital and parental issues provide opportunity for the illness to become the organizing family issue. The adolescent who is ill may use illness-maintaining behaviors to cross generational boundaries in order to regulate marital distance and parental conflict. This behavior will polarize, immobilize, and fragment the family in such a way that opposing sides are taken concerning the illness. Parenting thus becomes an adversarial process, with each parent overtly and covertly recruiting members.[49]

Scapegoating and the Phases

It is important, at this point in the discussion of conflict management within the family system and the different phases the system will go through throughout the duration of the illness, to mention the role of **scapegoating** within the family system. One effect of a pathological reaction of the family system is the possibility that the family may displace its anger and guilt over the diagnosis, course and/or outcome of terminal illness and create the role of the scapegoat.

The concept of scapegoating can be seen throughout history. The term comes from the Old Testament (Leviticus

---

[48]Ibid., 252.

[49]Ibid., 253.

16:8, 10, 26). Scapegoat originally meant one of the two goats received by the Jewish High Priest in ancient Jerusalem on the Day of Atonement. One goat was for Jehovah, the Hebrew God, and was killed as a sacrificial offering. The second goat was called the scapegoat. This one was for Azazel, which may have been the spirit of evil. The priest laid his hands on the scapegoat as he confessed the peoples' sins. Then the priest sent the scapegoat into the wilderness. This was a symbol that the sins had been put away, or forgiven.[50]

Today, when somebody refers to a person as a scapegoat, it means he or she has been made to take the blame or bear the burden for something which is the fault of another; it is the process by which one finds a substitute victim on which to vent anger. By condemning the scapegoat, one is able to vent one's feelings without attacking the real subject of one's anger or blaming oneself. It is quite common for families to utilize a single member as a scapegoat to maintain the coherence of the family. The projection of hostilities to the outside via the scapegoat helps some families achieve unity. The function of the scapegoated individual here is to channel family tensions and to

---

[50]Raymond Corsini, ed., Encyclopedia of Psychology, 2cd. ed., s.v. "Scapegoating," by W.E. Gregory.

provide the family with a basis of solidarity.[51]

When applied to family therapy, the classical metaphor of scapegoat refers to situations in which parents see or engage problems in another individual in an attempt to resolve a conflict between themselves.[52] Pillari states that unresolved tensions in the family are factors which are crucial to the scapegoating role. One common way the family discharges this tension is to find an appropriate person to symbolize them.[53] In families with chronic illness, scapegoating can be viewed as coping behavior to deal with issues that do not disappear.[54]

A typical form of scapegoating may involve the relationship between both parents and a healthy child in the family. Scapegoating a child serves to relieve the guilt that parents experience and prevents them from facing it. The scapegoating may occur with the parents' being annoyed at their healthy child and continually finding fault with whatever he or she does. Until the parents can come to

---

[51]Vimala Pillari, Scapegoating in Families: Intergenerational Patterns of Physical and Emotional Abuse. (New York: Brunner/Mazel, 1991): 4.

[52]F.B. Simon, H. Stierlin, and L.C. Wynne, The Language of Family Therapy: A Systemic Vocabulary and Source Book. (New York: Family Process Press, 1985).

[53]Pillari, Scapegoating in Families, 18.

[54]Ibid., 35.

grips with their feelings, the child will remain a scapegoat.[55]

In dealing with their anger over a diagnosis, family members may bitterly accuse the health care providers of not giving proper treatment or of making a wrong diagnosis, they may blame God, or they may become angry at the family members who are not sick.

Scapegoating may, on the other hand, occur in a family as a way of reaching homeostasis when the individual who is sick was the family's previous scapegoat. In this case, the scapegoat role may be reassigned, and if roles are not realigned to incorporate this newly assigned scapegoat in the operational dynamics of the family system, the unit will be in threat of collapse.[56]

We have examined the conflict management patterns and possible difficulties within the family system faced with the terminal illness of one of its members, including the significant concept of scapegoating within the coping process. Each of the three phases of illness--the diagnostic, adaptive, and end stage--poses special risks and requires different defenses and coping capacities in the problem-solving techniques employed by the family system. I

---

[55]Goldberg, "Family Tasks and Reactions in the Crisis of Death," 404.

[56]Ibid., 404.

will now turn to a brief discussion on the communication patterns employed by these family systems.

Communication Patterns

How a family system will survive the stress of the illness will be reflected in its ability and capacity to facilitate open communication. We have seen how effective communication or lack of it plays a significant role in the family's level of cohesion and adaptability, and its images, themes, boundaries, and social interaction. Throughout the process of dealing with the crisis of terminal illness, communication among family members either facilitates or hinders the adapting of the system to meet the demands of the stress.[57]

Research has shown that families with open internal communication systems are more prone to resist the societal taboos surrounding terminal illness and death, and are thus more likely to discuss and make realistic plans for and with the ill family member and, if necessary, prepare for their death. It is important to note that whether or not a family's pattern of communication is open is influenced by the intergenerational patterns of communication which precede it. A family that consistently deals with stress by

---

[57]Kathleen M. Galvin and Bernard J. Brommel, Family Communication: Cohesion and Change, 3rd ed., (New York: HarperCollins, 1991): 250.

attempting to "assess and absorb the reality components of the situation rather than by trying to deny them," is able to cope more effectively with the immediate crisis, and more readily alter the generational patterns of communication and meaning it has inherited.[58]

The degree to which it is permissible within the family's communication style to express feelings of sadness and loss, as well as less acceptable feelings of hostility, anger, guilt and relief, plays a significant role in how well the readjustment period, both during the illness and after, will proceed. The intergenerational wounds around these areas of loss and anger which the family has incorporated into its functioning are significant factors influencing the expression of such feelings in the readjustment and coping process.

David Wellisch has found that those families who experience the greatest difficulties in coping with terminal illness are those in which one of its members previously had significant psychological difficulties. Thus, the inability to emotionally adjust to terminal illness is not a unitary phenomenon but the latest example of long-term difficulties within the family system, especially in adjusting to life

---

[58]Vollman, "The Reactions of Family Systems to Sudden and Unexpected Death," 104.

changes.[59] When families express the fact that "cancer is the only thing we can't talk about," closer probing of the family's relational history and observation of current communication patterns usually proves this statement to be untrue. What families cannot talk about is not the terminal illness, but their feelings surrounding the suffering they are experiencing and their fears about the eventual death of one of its members.

Referring back to the stages or phases which a family goes through when faced with the stress of illness, the communications patterns of the diagnosis phase reveals how the family attempts to deal with a period of uncertainty during which the symptoms of the patient have been noted but not diagnosed. We know that the diagnosis of terminal illness will often be met by the family systems' initial avoidance of its full and realistic meaning, and it is often the case that information sought during this phase serves more of a reassuring function rather than one of education.[60] It is crucial here for familial communication patterns to be open and inclusive, so as to facilitate the expression and intrafamilial emotions and fear, as well as to facilitate dialogue between the family, the medical team,

---

[59]Wellisch, "Family Group Therapy in Oncology Practice," 228ff.

[60]Galvin, Family Communication, 245.

and extra-familial support systems.

During the adaptation and end phases, it is important that a lack of communication not block the necessary mourning process. The lines of communication must be kept open and the ill family member must be allowed both to express his or her feelings and be the recipient of the communicated feelings of other family members. As I have mentioned above, it is often the case with families faced with the stress of illness that the family members may feel that they are not free to share their negative feelings with the vulnerable patient. Protective mechanisms prevent the open expression of feeling and as the communication behavior of the family system reflects the tension of the stress of terminal illness, the communication system within the family shuts down on all fronts.

When appropriate communication measures are not employed within the system during stress, the family may find itself turning to other means of expression. The reality of cancer or terminal illness can arouse the "Christmas in July" syndrome in an overly protective family, when birthdays or holidays become the last opportunity to express love for the child or adult. On the other hand, because the anger, grief, anticipatory mourning, and ambivalence may be too much to experience openly and collectively, the illness can produce feelings of extreme

detachment in members of the family; or no communication at all may take place regarding the disease or its consequences to avoid the overwhelming feelings of helplessness.[61]

I have taken a conceptual approach to exploring the issue of terminal illness within the family system, examining the psychosocial management of families with a terminally ill cancer patient from a family systems perspective. A family systems approach to looking at how a family functions healthily and under great stress provides a thorough picture of the entire family as a unit. I have emphasized the necessity of understanding the family system as facing a series of adaptive tasks in relation to the illness, for families function in a perpetual psychological limbo in relation to the illness. As the articulate wife of one cancer patient has stated, "cancer is like another member of our family, an unwelcomed member."[62] The family system of a terminally ill patient moves into a state of "limbo" where interactions, plans, and socioeconomic realities are continually unbalanced and ever-changing.

In this chapter I examined familial patterns of coping and adapting to the unpredictable stress of terminal illness inclusive of the stages of family crisis in conflict management, the effects of the illness on the decision

---

[61]Cohen, "Living in Limbo," 567.

[62]Wellisch, "Management of Family Emotion Stress," 228.

making process within the system, the role of scapegoating within the family, and communication patterns in dealing with terminal illness. These are crucial areas to consider when examining the family's reaction to terminal suffering and their search for meaning. We have seen how intergenerational patterns of behavior and communication are influential in how the family adapts to new modes of functioning and reformulated understandings of suffering, illness, and death.

To this point, I have laid the ground for my discussion about scapegoating God within the family system. This thesis is concerned with families who scapegoat God in their attributional search for meaning and context, and I have used the concept of the nature of the family as a **system** to help us to understand how the family functions and copes with stress and how family reacts and adapts to the experience of suffering and terminal illness.

At the outset, I have explored the human experience of suffering and our need to search for meaning and context in the face of pain and despair. I have previously examined general attribution theory and its application to terminal illness and familial searches and constructions of theodicies using causal attribution to explain the genesis, course and/or outcome of an illness.

Examining the function of the family as a system,

with an eye to the intergenerational formulations of meaning and modes of incorporating that meaning into present functioning, has provided a relational context from which to understand and apply the notion of scapegoating God. At this point, both the exploration of attribution theory and its application to religious searches for meaning--which provided us with insight into the centrality of meaning in the process of seeking understanding in suffering--and the relational context which we have obtained from the above exploration of the family as a system experiencing terminal illness need to be integrated, as it is the integration of the centrality of meaning within human suffering and the coping process of individuals and family members which provide the context to discuss scapegoating God.

Using the information gathered from this exploration of the system's functioning in reaction to the experience of terminal illness, I will move on to focus on the family system's scapegoating of God in its causal search for meaning using the theodicy which sees God as both omnipotent and good, and how this scapegoating plays out in its religious and spiritual life during and after the crisis of illness.

CHAPTER 4

SCAPEGOATING GOD: SUPERNATURAL CAUSAL ATTRIBUTION AND A FAMILY'S CRISIS OF FAITH

Give sorrow words; the grief that does not speak
Whispers the oe'r fraught heart, and bids it break.

Shakespeare

We have seen how the complex reality of the experience of terminal illness plays out in the family system. We have explored the almost innate need for human beings to find meaning and context in their suffering and pain, and how this search often leads to the construction of theodicies which enable the family to question their God in their search.

The significance of the centrality of meaning is innate to human experience, and we have seen how the experience of suffering amplifies our need to search for meaning. The process involved in a family system's search for meaning when facing a terminal illness as challenging its previous understanding of the nature of God. Attribution theory within a religious framework and its application to terminal illness has given evidence of the tendency for families to construct theodicies to explain the genesis, course and/or outcome of an illness and the suffering they experience.

This tendency of families who operate within a religious framework to construct theodicies in order to understand and make sense out of their experience of suffering, when understood in light of the function of the family as a system under extreme stress, is all the more illustrative of the propensity which suffering brings forth for the implementation of some form of blaming and focusing anger on God.

At this point, I will examine what I propose to be a stage of **scapegoating God** in a family system's search for meaning and context in the face of their pain and suffering, using a theodicy which sees God as both omnipotent and good. I hold that this stage of scapegoating God is key in the coping process and will examine the shape of this stage in a family's coping process as well as propose that a necessary component of the coping process is movement through this stage to a place where the family is able to embrace the mystery of their existence and their struggle. This chapter will also focus on how this scapegoating plays out in its religious and spiritual life during and after the crisis of illness.

It should be stated at the outset that I understand this notion of scapegoating God as crucial to the coping process, and I approach this concept from a Christian perspective. Those who do not locate themselves within this

tradition are still, in my opinion, subject to the need for finding meaning in their suffering and to attribute cause and/or blame to someone or to something. In these instances, I find it appropriate to refer back to Maes' term Ultimate Context in reference to the God of whom I speak, with the understanding that for many individuals, this Ultimate Context may or may not represent a personal God.

Before moving on to discuss this concept of scapegoating God, and the effect this scapegoating has on the family's religious or faith orientation, I will briefly explore some of the literature and research to date on the essential components of the coping process.

Notes on the Coping Process

It is important at this point that I say a few words on what I mean by crises and stages. I will use the understanding of crisis which Erik Erikson has been so successful in incorporating into his developmental theory. I will also point out the nature and shape of this crisis as a **stage** by referring to Elisabeth Kübler-Ross's presentation of the coping mechanisms or stages which terminally ill persons progress through.

The developmental theory of Erik Erikson, although in need of a contemporary, critical review, serves as a great point of reference for me as a pastoral counselor in that his focus is not on pathology, but on the normal devel-

opment of the healthy personality. His theory of psychological development involves eight stages which span the entire life of the individual. At each of these stages the ego is confronted with a developmental crisis, the successful resolution of which leads to further healthy growth; the failure to successfully resolve the crisis leads to immaturity and possible pathology.

Erikson refers to **crisis** to connote not a threat of catastrophe but a turning point, a crucial period of increased vulnerability and heightened potential, and therefore, the ontogenetic source of generational strength and maladjustment.[1] The word crisis refers to a **normal** set of stresses and strains.

I understand crisis to be a time in which the acquisition of a new capacity is required in order to negotiate the stress and strain which the crisis presents, and to move through the crisis to a higher level of functioning. It is this understanding of crisis which I am referring to when I speak of a crisis of faith which the family encounters in their search for meaning and in their construction of specific theodicies which enable them to view their God in a different light. I do not understand a crisis of faith as a threat of catastrophe, but as a turning

---

[1]Ibid., 96.

point; as an opportunity for growth, for openness to community, as a time of personal and spiritual vulnerability which serves as a source of inner fusion and strength.

This offers some insight into my understanding of crisis, but what of the **stage** involved in scapegoating? Psychiatrist Elisabeth Kübler-Ross, in her ground-breaking work, On Death and Dying, describes five reactive phases through which terminally ill persons and their families progress. These phases are called **coping mechanisms**, and have been designated as denial, anger, bargaining, depression, and acceptance as an aid to assist those dealing with individuals who are terminally ill and their families to better understand the process and experience of terminal illness.

Kübler-Ross's second stage of anger is of particular interest to this investigation. It is within this realm where I see the potential for individuals and their families to move into a period of such intense anger that it becomes necessary to displace this anger onto anything or everything around them as a means of coping with their stress.

She explains that when the first stage of denial can no longer be maintained, it is replaced by feelings of anger, rage, envy, and resentment. The logical question at

this stage is "Why Me?".[2] Terminal illness brings with it the prospect of tremendous loss, the loss of one's life, preceded by multiple losses of capability or freedom. People feel angry in the face of these losses, and the more severe the loss, the greater the anger may be.

This stage of anger is very difficult to cope with from the viewpoint of family members and medical personnel. The reason for this is the fact that this anger is displaced in all directions and projected onto the environment and at times almost at random. Angry patients or angry family members may lash out at anyone around them. They may direct their anger at friends, co-workers, at God or at the medical staff. The doctors are just no good, they don't care, they don't know what tests to require and what diet to prescribe. The nurses are lazy and cruel, and the room is poorly ventilated. They keep the patients in the hospital too long or don't respect their wishes in regards to special privileges.[3]

It is common for feelings of guilt and shame to arise consecutively with the feelings of anger. This is of particular importance when the anger people are expressing has been directed toward God. By directing anger at God,

---

[2]Elisabeth Kübler-Ross, On Death and Dying: What the Dying have to Teach Doctors, Nurses, Clergy, and their own Families. (New York: Macmillan Publishing, 1969): 44.

[3]Ibid.

people find themselves in a sort of double dilemma: even though they feel angry at God for what is happening to them, they feel guilty that these feelings may be sinful or blasphemous, and fear that God may punish them.[4]

Although all of Kübler-Ross's stages have significant bearing on individual and familial relationships with God, i.e., denial of God, bargaining with God, etc., it is in her second stage of anger where I have located my stage of scapegoating God. I have relied greatly on her presentation of the nature of this anger stage, the feelings and thoughts associated with this stage in the process of dying or dealing with a terminal illness, and have shaped and formed my conclusions and theory based on this anger stage. It is not difficult to see how easily the family system's notion of scapegoating fits with her understanding of the defenses of projection and displacement used in the coping process. The power of the anger present is key. What makes it applicable to this understanding of scapegoating God is the direction in which this anger is displaced.

Questioning God: The Family In Crisis

Talking about a family's crisis of faith which is both the cause of and results from questioning God assumes that the family is doing just that - questioning God. Some

---

[4]Ibid., 46-7.

may conclude that to assume that families address God in their pain and suffering is inappropriate. There are those, in fact, that do not turn to their God in times of strife and struggle, reserving that medium for merely the pleasures or "fluff" of life. However, I understand crises such as those brought on by terminal illness as **necessitating** confrontation with God. I tend to agree with Hauerwas when he states that ironically, the act of unbelief turns out to be committed by those who refuse to address God in their pain, thinking that God just might not be up to such confrontation.[5] After all, was it not Jesus Himself who cries out, "My God, my God, why hast thou forsaken me?" (Mark 15:34).

Unfortunately, many approach the area of questioning God's intentions in their life as a sort of religious blasphemy. In the case of terminal illness, as I have discussed earlier and as Kübler-Ross has indicated, many individuals and families feel guilty when they turn to their God for answers to their questions of "Why?" It is here where I want to make the contention that it is only in turning these ultimate questions to our God that we can manage the stress in the coping process of not knowing, and of coming up with questions unanswered.

It is important here to say a word about the nature

---

[5]Stanley Hauerwas, Naming the Silences: God, Medicine, and the Problem of Suffering. (Grand Rapids: Eerdmans, 1990): 84.

of such faith. I understand faith, most importantly, to be dynamic, not static, and about a relationship, inclusive of historical meaning. Viewing faith as static necessitates that we accept that faith would not change no matter what happens. In other words, experiencing terminal illness would have no effect on the nature of one's faith, for experience would not inform faith. Seeing faith as dynamic means allowing for the incorporation of on-going change and development in one's relationship with God and perspective on life.

We know that terminally ill patients and their families experience constant change, emotionally, physically, financially, socially, etc. When we look to the area of families questioning their God in times of faith crises, seeing faith as dynamic enables us to embrace the change and the development possible when such challenges present themselves in relation to our faith. Life challenges become opportunities for spiritual growth and development, not as fearful times filled with a threat of spiritual devastation.

Understanding faith as focusing on relationship and meaning is also essential. Many people might understand their faith as dependent on an adherence to certain dogmas or traditional religious practices. However, with the onslaught of major crises such as having to deal with terminal illness, many individuals find that their faith

rests on their new relationship with God and the new understanding and meaning which this relationship provides. As Gerald Calhoun has stated from his experience working with the terminally ill, in crises such as death and illness there is often a painful gap between what people understand of God and their feelings toward God.[6] Consequently, people find themselves in the midst of a struggle to re-interpret and understand who God is for them in light of their new experiences, and the new understanding which is forged from this struggle is what is transformative in their suffering.

Given the dynamics at work in most crises of faith and in faith development in general, it is understandable that in times of great existential, physical struggle that people turn to their faith for answers to questions which are not answered by other means. It is only in turning these questions to our God that we can manage the stress of the crisis and the coping process, it is only in being able to turn to our God with our questions that we may find comfort in not knowing, where we hope to find relief from coming up with unanswered questions, and where we come to a place of new understanding of the mystery of our existence.

In my work with cancer patients and their families,

---

[6]Gerald J. Calhoun, Pastoral Companionship: Ministry with Seriously-Ill Persons and Their Families. (New York: Paulist Press, 1986): 27.

if I could communicate only one message, it would be that God is the only source of hope and peace that we will find in times of great pain and suffering. I have come to the conclusion in my own search for understanding and meaning, that it is an expression of great faith and trust to turn to our God with these never-ending questions and to ask "Why? Why me God?"

The biblical story of Job illustrates this change or shift to new understanding. Job spends thirty chapters arguing with friends and with God, protesting his suffering as unjust for he was a righteous man. This is a good illustration of how Job's **relationship** with God, and how his understanding of God changed through his struggle, and was central to his process of working through his grief. Could it be that the author of Job was trying to communicate that Job was correct in questioning his God for the wrongdoing he was experiencing? Job's questioning God and directing his anger at God was not an act of faithlessness, but an act of great commitment to his God. Instead of walking away from God in disgust with unanswered questions, or being fearful of directing his anger at God, Job remained in the battle, questioning his plight and releasing his burden of anger, confusion and fear to a God he knew could hold his anguish.

Scapegoating God: Coping with the Anger

Some may argue that it is one thing to question God

about the experiences of this life, but quite another to direct blame and anger at God as the cause of those experiences. The act of questioning carries with it the possibility that answers may not come, or that answers one might expect or hope for are not what is discovered. It is the despair and the frustration which comes from unanswered questions as to "Why?" which lead to the necessity of directing the ensuing anger onto God.

We have seen from Kübler-Ross's work on the stages of coping with terminal illness and dying that the stage of anger is very difficult to cope with. We know that feelings of guilt and shame arise consecutively with the feelings of anger. The double-dilemma which people experience when they feel guilty for directing this anger and blame toward God is, in my opinion, because they understand that placing anger and blame on God is sacrilegious. As Christians, we have a tradition which is full of a history of focusing anger and blame on God. Jesus was maligned, isolated, threatened, rejected and ultimately condemned to death. Is this not scapegoating?

This stage of scapegoating God is not only **acceptable** in the coping process, in that it is an act of faith to address such feelings and thoughts to God or to our Ultimate Context, but also as a **necessary** step in the coping process when we are struggling with such great dilemmas as terminal

suffering. This is especially applicable for those who **do** locate themselves in relationship with a personal God; a relationship which causes one to question faith; a relationship which is subject under such pain and confusion to strain and collapse. I see God's sacrificial act of sending Christ Jesus to die on the cross for our salvation as the ultimate acknowledgement that it is acceptable and that it is necessary to turn our anger and pain to God.

I understand this process of scapegoating God as acceptable in that we must turn these frustrations to our God because ultimately, God is the only source we can find in this life to answer questions about life and death. Answers for the meaninglessness we find in suffering can only come through continued relationship with God and community which open us up for embracing the mystery of this life, and allow for seeing the grace in the silence. I understand the stage of scapegoating God as necessary in that we must wrestle with God concerning our feelings of abandonment and neglect in relation to our experience, in order to maintain a healthy relationship with a God who we understand to be omnipotent and merciful, yet who allows our suffering to continue.

This stage of scapegoating God is necessary in that if individuals do not express their rage and anger at their God in their struggle for meaning, if they are not able to

release their frustration and confusion in regards to their faith and their relationship with God, there is potential for this crisis of faith to lead individuals to permanently reject God and abandon all hope. Not only does this severing of the relationship with God cause greater despair while within a crisis, but it also has the potential for individuals and families to indefinitely reject their God and refuse further relationship with the God of their faith.

If we acknowledge that we will not have the answers to all things in this life, how can we not look for assistance in these areas from the God of our faith? After all, is this not the basis of our faith, that we are dependent on a power greater than ourselves for all that lies beyond the scope of our existence? God does not place limits on what is acceptable to question and what is not. To say that all areas are "up for grabs" negates the severity of the fact that God can handle anything and everything. What needs to be stated simply is that God can take it.

The anguish of meaningless pain and suffering cannot be relinquished through worldly means of reason and justification. From within our Ultimate Context, we cannot, therefore, **not** turn questions as to why things are the way they are, as to why people must suffer and grieve losses, to our God who is our only hope in receiving some form of peace and reconciliation with the "stuff" of this life.

I believe that this stage of scapegoating God is necessary when one is wrestling with one's faith for the sake of salvaging one's relationship with God. When questions of "Why?" are directed to God and an answer seems forever off in the distance, we are then faced with dealing with feelings of abandonment and neglect. How can God be so silent to my cries? One might be forced to proclaim that "not only are You allowing this to happen, but You are ignoring me in the process!"

Scapegoating God is necessary in order for the person to remain in relationship with their God. All too often God is ignored and forgotten after a devastating crisis which might have left individuals feeling as though there was no God at all. If these feelings were directed toward God, not only are they not being repressed, but the lines of communication with God are still open. I see this notion of scapegoating God, therefore, as critical in order to maintain a healthy relationship with a God who we understand to be omnipotent and merciful, yet who allows our suffering to continue. It is also necessary in that I believe that it is only with the support of our faith are we able to grieve the losses experienced through terminal illness and death.

It is important to note that this stage of scapegoating God should not be viewed as part of a progressive staging process, such as the one Kübler-Ross presents of the

steps and phases of the dying process. This is because each individual and family system experiences the reality of terminal illness differently, and may or may not find themselves at a place in their emotional coping that they experience this anger or resentment toward God. Also, it is not my intent that this stage of scapegoating God be evaluative, as though progression to and through this stage were markers for healthy coping and growth.

Scapegoating as Process:
Movement Toward Resolution of Grief and Anger

Central to this notion of scapegoating God as acceptable and as necessary is the understanding that this is a stage in the coping **process**. A necessary component of this coping process is movement through this stage of scapegoating God to a place where the family is able to embrace the mystery of their existence and their struggle. I do not propose that in scapegoating God, one winds up blaming God or being angry with God indefinitely. Rather, I see this scapegoating as a process, as a time in coping when individuals and family members can appropriately release their anger and shame, while maintaining a relationship with their God during crisis. It is a time when these feelings can be shared, when anger can be embraced, not avoided, and feelings of isolation and abandon need not overwhelm the suffering.

I cannot help but be reminded of the significance of the paschal mystery in this discussion, as I write on Holy Thursday. I understand scapegoating God as response to suffering and pain as offering the potential for new life, for new relationship with God, just as the blood of Jesus became the mediating reality in a new relationship between God and human beings.

We know that answers do not come for all things in this life. We know that our friends and family cannot answer the unending questions of "Why?" and their consolation often falls short of what we truly need in our pain. I do find consolation, however, in the fact that Jesus experienced the same thing. He turned to his brothers in the garden of Gethsemane and asked that they sit with Him and pray, but all they could do was sleep. He could not find the consolation in those of this life. Jesus sought consolation from God, saying, "remove this cup from me" (Mk. 14.36). In His final hour of tremendous suffering, Jesus again turns His anger and frustration toward God in the darkness on the cross screaming, "My God, my God, why hast thou forsaken me?" (Mk. 15.34). Then, in His last breath, He offers a final cry, and is united with His God.

Jesus' last moments serve as an ultimate example of how in turning our frustrations and anger or blame to God, we are united with our God in ultimate solidarity. The

passion, death and resurrection give evidence that in our suffering, in our cries to our God of "Why?", our suffering is transformed, it takes on new meaning. In the blaming, in the screaming, we are united with our God just as Jesus was in Gethsemane.

Our suffering in this life is transformed through the eschatological hope of Christ's death and resurrection. It is interesting that the stories of Christ's appearance after the resurrection mention His physical wounds (Jn. 20.27). The wounds do not disappear, the suffering is still evident, but the wounds and the suffering themselves become the source of resurrectional power. Our suffering and our pain do not disappear when we turn our anger and anguish to God, but I believe, through the transforming power of the grace of God, our suffering can be turned into something new, and our relationship with God can continue to make us whole.

Turning to the paschal mystery for insight roots the experience of Christian individuals and families within their tradition and offers hope in the face of continued pain and suffering. It also provides an example that our relationship with God and our understanding of the nature of God is subject to change through the experience of suffering. This insight is of assistance in moving through our grief and anger.

The paschal mystery serves as a testimony to the fact

that although our attributional search for meaning may lead us to a place of such severe confrontation with our God that there seems nothing left in the relationship to salvage, there is hope and peace in the confrontation. There is hope in the resolution of our fear, our frustration and our cries of desolation.

It is precisely because of our need for hope and reassurance that I see this stage of scapegoating God in the coping process as acceptable and necessary; it provides opportunity for the **resolution** of our anger, our grief and our pain. Our relationship with God cannot help but be altered by our experience of suffering, or of the pain and fear in the eyes of loved ones who are dying. Oftentimes these experiences leave people bitter and resentful of a God to whom they have been faithful, yet a God which leaves them feeling isolated and betrayed by the suffering and the silence in their lives.

Turning one's anguish and questions to God allows for continual dialogue. It allows for the maintenance of a relationship which may at times feel extremely one-sided; it maintains a connection with God which may have otherwise been terminated. It allows for individuals and their families to move through their pain and anger with God to a place beyond the suffering, beyond the grief, to a restored relationship with a God who is there for them during their

struggle and who will console them in their grief beyond the trials of this life.

The process involved in a family's search for meaning in the face of pain and suffering challenges their previous understanding of the nature of God, and opens us up for new relationship with the God of our faith. We remain in new and ever-changing relationship with God despite a lack of meaning in our suffering. We are able to embrace the mystery of our existence and through new relationship with God, are able to give new meaning to this life and to our ultimate death.

We have seen how the experience of suffering amplifies our need to search for meaning and context in the face of pain and despair. Out of this despair, using attribution theory within a religious framework, we have seen the tendency for families to search for and construct theodicies in the coping process to explain the genesis, course and/or outcome of an illness and the suffering they experience. A theodicy which sees God as omnipotent and good allows for continued relationship and the development of new meaning in the face of great pain. This existential theodicy can hold our anger and our blame, moving us through our desolation to new life and insight. Scapegoating God is **part** of that process, as is movement through this stage by way of resolution of their grief to a place where the family

can embrace the mystery of their struggle and the grace which comes with silence. I will now move on to present some therapeutic and pastoral implications for living with the effects of terminal illness on self, family, and God.

CHAPTER 5

LIVING WITH THE SILENCE - EMBRACING THE MYSTERY: THERAPEUTIC AND PASTORAL IMPLICATIONS

> I do not believe that sheer suffering teaches . . if suffering alone taught, all the world would be wise since all the world suffers. To suffering must be added mourning, understanding, patience and love, openness and the willingness to remain vulnerable.
>
> unknown

We have seen that the sudden diagnosis of terminal illness of a family member can be experienced as a severe crisis for family members and for the family system. The impact of terminal illness on the family system has social, financial, psychological, and spiritual consequences that at times may be more debilitating than the illness itself.

As we approach the third millennium, new advances in medical and pharmaceutical technology add to this complex experience, changing the pattern of terminal illness, lengthening life, and consequently, increasing long-term care needs. This change in the course and outcome of serious illness has major physical, financial, spiritual, psychological and social effects upon the individual patient, his or her family, and society. These changes have brought about the need for a re-examination of the importance of appropriate psychological, and socially

and spiritually supportive care of the patient and family.

In addition, recent research has revealed that familial and societal dysfunction may even **promote** illness. Salvador Minuchin has studied children with severe asthma, superlabile diabetes and anorexia nervosa, and has shown that interactions within the family can cause or aggravate an illness in a family member with a genetic predisposition to the disease.[1] Furthermore, a psychosocial approach to the etiology of disease has proposed the widely accepted idea that emotional factors play a predisposing and precipitating role in the onset of illness. They are, however, only parts of the whole mosaic of variables that contribute in varying amounts to the genesis and outcome of disease.

In light of this information, recent research in medical social work has proposed that rather than focusing attention on the psychological causation of physical illness, various fields of expertise, i.e., psychiatry, psychology, neurology, social work, would benefit more from an exploration of

> the way in which the course and outcome of illness are affected by psychosocial variables once it has taken hold. Social and emotional factors may exert a decisive effect on the way the somatic illness develops,

---

[1]Salvador Minuchin, L. Baker, and Bernice L. Rosman, et al., "A Conceptual Model of Psychosomatic Illness in Children: Family Organization and Family Therapy," Archives of General Psychiatry 32 (1975): 1031.

> the degree of impairment that is engendered, and the way in which the individual and family adapt to it.[2]

This approach requires an understanding of the family system as facing a number of adaptive tasks necessitated by terminal illness, and how emotional, psychological and spiritual crises are approached and dealt with in the family's coping process.

The past two decades have seen an enormous amount of literature on death and coping with illness, focusing on the dying individual and the issues and stages inherent in coping with the dying process. The dying person is, however, always part of a larger family system of relationships that is transformed by the prospect and reality of death and terminal illness. In addition to understanding the coping process of the dying person, therefore, it is equally important that the coping process of the family system and of society in general be understood.

This understanding has been incorporated in this thesis, examining the effects of terminal illness on the individual and his or her family, and I have explored these effects on the coping process and the family's search for meaning. We have seen that the process of and purpose for constructing a theodicy which questions or blames God,

---

[2]Mildred Mailick, "The Impact of Severe Illness on the Individual and Family: An Overview," Social Work in Health Care 5 (Winter 1979): 118.

allows the family to attribute supernatural causality to the genesis, course, and/or outcome of the disease in order to find meaning in the suffering, and enables further relationship--a new relationship--with God, as well as new way of understanding the meaning of this life and of the life beyond death. This questioning and/or blaming is a key stage in the family's coping process. This stage must be viewed in terms of process, with an essential aspect of the coping to be successful negotiation of and movement through this stage to a place where the family is able to embrace the mystery of their existence and their struggle.

For successful negotiation and movement through this stage, one must ultimately, in confronting their anger with God, move to a place where one can work through this anger and the guilt and shame which accompany it. I believe that this can only be done by initiating and engaging in grieving the losses incurred in our suffering and in our pain. The losses are many, and too numerous to mention here in their entirety. When I speak of loss I am not merely referencing the loss of life, through death, of the people that we love or of our own lives. The experiences of this life, inclusive of experiences such as terminal illness, are embedded with loss and the need for letting go. As Judith Viorst states so eloquently, "losses are a part of life--universal, unavoidable, inexorable. And these losses are

necessary because we grow by losing and leaving and letting go."[3]

The losses to be grieved in terminal illness such as life itself, physical stature, old familial roles patterns of behavior, relationships, as well as the loss of an old way of relating to God must be confronted and mourned in the coping process in order for true healing and reconciliation to take place.

It is important to note that although this stage of scapegoating God names a time and place for families and individuals to address their anger and grief and to work through their feelings, this process does not promise absolute assurance and complete understanding. People have been asking questions of "Why?" and confronting their anger and grief which has accompanied such questions since the beginning of time. Despite thousands of years of asking this same question, centuries of scientific advances, despite the suggestions of philosophers and theologians mentioned above, the question of "Why" cannot help but bring all of us to a point where we must face the deep mystery of our God and embrace its silence on our hearts.

What I would like to communicate here is that

---

[3]Judith Viorst, Necessary Losses: The Loves, Dependencies and Impossible Expectations That All of Us Have to Give Up in Order to Grow. (New York: Fawcett Gold Medal, 1986): 3.

although by naming the reality of the anger and frustrations directed toward God in our questioning offers us a point of reference and a common language from which to talk about such feelings, this stage is not the end-all or final answer to the problem of anger and frustration with God. By proposing the existence of this stage of scapegoating God, I do not want us to forget that in turning our questions to God we must be consciously aware of the fact that the answers may come just as slowly, just as silently as they did from our worldly efforts.

It is in light of this that I want to suggest that in addition to incorporating this "stage" thinking into the coping process of those experiencing terminal illness, we must also be sensitive to the fact that eventually we must all embrace the mystery of our existence, even the silence which at times falls so heavy on our hearts. To conclude this examination, I shall end as I began, by presenting some thoughts on living with this silence and embracing the mystery before us about God, about family, and about living.

About God

Embracing the mystery of our faith and of our existence, with regard to the experience of terminal illness, necessitates that we incorporate an understanding of the spiritual crises that such illnesses provoke, and the methods which family members, and the system in general,

will undertake in order to explain and understand their suffering and their pain. A family system's crisis of faith need not result in spiritual isolation and feelings of abandonment. By looking to this stage of scapegoating in the family's coping process, we can see new possibilities in overcoming the stress and anguish which terminal illness ravages in the minds and souls of those close to its destruction.

Embracing our faith in times of struggle also requires that we come to a personal understanding of the mystery of suffering, and that we experience anew the God of our faith and the changes in relationship that this will cause. The story of Job is a classic illustration of the view that suffering is mysterious, and that this experience changes our relationship with God. Although at the end of the story God finally gives an answer to Job's long and arduous speeches of protest, God never really explains Job's suffering. God merely gives evidence of God's great works and of God's omnipotent power. Having experienced God's power, Job throws his face into the dust and says,

> Therefore I have uttered what I did
> not understand,
> things too wonderful for me, which
> I did not know.
> 'Hear, and I will speak;
> I will question you, and you
> declare to me.'
> I had heard of thee by the hearing of
> the ear,
> but now my eye sees thee;

therefore I despise myself,
and repent in dust and ashes.

Coming to an understanding of pain and suffering as grace-filled mystery can only be done on a personal level; it cannot be achieved through study or through guidance or through imagination. Individuals and their families must go it alone with their God. Ministers, medical professionals and others may be of assistance through encouragement and solidarity, but ultimately, this experience and understanding can only be wrestled with with the companion of faith.

Others such as professional counselors and medical staff would benefit well in developing compassion and patience in this area, not only with the assistance from an elaboration of current methods of dealing with the stress of a family with serious medical conditions, but from developing and understanding new approaches which build carefully on research in areas of familial stages of faith, spiritual crises, divine attributions, and social oncology. The community as a whole must search diligently to be of assistance in finding a place for the illness within the familial faith structure, while ensuring that the illness is kept in its place.

What individuals and families need is a reframing of their presenting problem to normalize their experience of directing their anger at God and using God as a scapegoat in their coping process. The family needs to understand the

freedom which scapegoating affords the grieving process.

We cannot approach the experience of terminal illness with the mere objective of assisting the family to live a psychologically and functionally healthy life with optimal creativity and involvement if it is not inclusive of a communication of the importance of grieving losses and the maintenance of a healthy spiritual life and relationship with their God. If this is our objective, we must be sensitive to the process the family engages in its search for meaning, for the ultimate, religious attributions the family will make regarding the suffering in their life has a direct ramification on the continued relationship with themselves, others, the world, and especially, with God.

About Family

In addition to proposing that psychological, emotional health needs to be considered alongside the spiritual health of the individual and the family system, I also hold that patient health and familial health are synonymous. With this in mind, chronic medical conditions and terminal illness present unique challenges to the family therapist.

An approach to treating the patient and his or her family must be sensitive to a holistic psychophysiologic understanding of the individual and his or her disease; the individual and his or her family; the family and the medical

staff; the religious and spiritual orientation of the patient, the family and the community; and the social, institutional, family and patient systems which are overlapping and mutually interactive in the genesis, course and outcome of disease.

Because I experience the complex management of terminal illness as a process which involves medical, psychological, and spiritual adaptation, a multi-disciplinary approach, which embraces the individual and familial fears, anxieties, and personalities, must be considered side by side with the medical regimen.

The role of the family therapist has primarily and historically been defined as supportive of medical management. As Sheinberg has elaborated

> In responding to chronic illness as a significant piece of family information, the family therapist can begin to understand how the illness affects and is affected by the system of which it becomes a part; it is this conceptualization that opens up new possibilities for intervention.[4]

The family therapist has a large task before him or her when working with a family facing terminal illness. The family must be assessed as to its developmental level, its unique style of communicating and making decisions and the patterns of interaction and their flexibility in times of stress. In addition, for the pastoral counselor, the

---

[4]Marcia Sheinberg, "The Family and Chronic Illness: A Treatment Diary," Family Systems Medicine 1 (Summer 1983): 26.

spiritual crises must also be confronted and incorporated into the treatment plan.

My experience has shown me that there must be a smooth coordination of effort, inclusive of continual, direct communication between the therapist, the medical health care team, and ministerial representatives in order to effect a positive coping and psychosocial outcome. If there is fragmentation or non-communication, the family will sense this and it will only increase their anxiety and decrease their ability to cope.

The family therapist should provide services that will support the family's social functioning without taking away their autonomy.[5] The family therapist facilitates the expression of feelings, provides and/or helps the patient and family to seek appropriate information regarding the illness, encourages their active involvement in the diagnostic process, suggests resources that might be useful and helps them to understand and accept the diagnosis. The therapist encourages the maintenance of self-esteem and emotional integrity of the patient and the family. This requires that therapists know their own reactions to terminal illness and respond to the patient and the family without losing their own sense of balance and identity.

---

[5]Mailick, "The Impact of Severe Illness on the Individual and Family," 122.

Some distance is essential to avoid being inundated by the family's fear, shock, shame, guilt, and anger, yet closeness is essential for the expression of empathy and support.

The tendency to avoid the anxiety-laden issues surrounding terminal illness is strong for family members and therapists alike, and both groups are therefore in need of a wide base of support in order to help them cope.[6] Religious, communal and social support base for families and therapists alike is crucial here. In fact, researchers have found, in general, that the degree to which families allow for and benefit from outside intervention is a function of their incorporation of the norms and values of the larger society into their own familial value system.[7] This information has severe ramifications on the degree to which we hold our community, our society and our church accountable for mirroring and facilitating a positive stance toward appropriate familial norms and Christian values.

I have not had the opportunity, in a paper of this length, to investigate the family as part of the larger system within which it thrives. Suffice it to say that the family as a system must always be considered in light of the community within which it is located, the value systems of

---

[6]Wellisch, "Family Group Therapy," 229.

[7]Vollman, "The Reactions of Family Systems to Sudden and Unexpected Death," 104.

the family's society, the meaning of illness and death, and the relationship between faith, culture, society and illness. Just as the whole of the family system is greater than the sum of its parts, the family system is part of a much larger whole, and these influential factors must always be given careful consideration in any attempt to fully understand the family system as it relates to terminal illness.

In fact, the community may well have much to learn from families experiencing great suffering. Hauerwas states that there is virtually no reason at all why we cannot make the suffering of others "part of the telos of our service to one another in and outside the Christian community."[8]

About Living

I have seen a prevailing attitude toward life as mystery and as gift among persons and their families who have experienced first hand the anger, fear, guilt, shame, and confusion associated with terminal illness. The men and women that I have spoken with stand in awe of the mystery of their existence, and the miracle of their continued life here on earth. They are able to look back on their experience and to live the effects of that experience in the here and now, encompassing and embracing the mystery of

---

[8]Hauerwas, Naming the Silences, 89.

their own suffering and the silence that they pondered so during their struggle.

Howard Brody has stated that "suffering is produced and alleviated by the meaning one attaches to one's experience."[9] He goes on to state that the primary human mechan-ism for attaching meaning to particular experiences is to be able to tell stories about those experiences. Adding to that the notion of the centrality of meaning in our search for context and understanding in suffering, Brody's statement has important ramifications for living with the silence of our struggle. We are mandated, as seasoned veterans of the experience of suffering, and, as members of the larger community, to share our experiences of the hurt and pain of this life with others. Sharing our pain and suffering with the larger community alleviates isolation of the individual sufferer, as well as the isolation the members of the community feel as bystanders.

Looking back on an experience, re-telling one's story is very different from giving testimony to the hurt and the anguish while one is living it. It is my hope that in the experience of terminal illness, individuals and their families will be able to recognize and embrace the grace in the suffering and the fruit of having confronted their fears

---

[9]Howard Brody, Stories of Sickness. (New Haven: Yale University Press, 1987): 5.

and addressed the unmentionable, especially in relation to changes in familial ties and spiritual wholeness.

All of those I have talked to have reaffirmed that coping is two-dimensional: there is the need to cope with the event itself, and the need to cope with one's feelings and behavior in relation to that event. Those who have experienced terminal illness understand that their charged emotional states of fear, anger, guilt, denial, were not merely the result of mismanaged stress. People get angry for reasons other than being incapable of handling any given situation. Getting at the "Why" behind people's anger is not as important as understanding what to do with the anger. This is central to the purpose for this investigation: that in their anger people come to recognize that there can be redemption in our suffering; that there is new life in relationship with God, the understanding of which has been transformed in and through the suffering; and that the greatest struggle of all is for individuals and their families to arrive at a place beyond the anger, to reconcile with their God, with their families, and with self, a place where they can rejoice in new relationship and with new understanding of the mystery of this life and of the grace of the God of their faith.

Alexander Solzhenitsyn, the great Russian novelist, spent eight years in the deplorable work camps of the Soviet

Gulag, suffering horrible indignities. Nevertheless, Solzhenitsyn looked back on those eight years' imprisonment and prayed, "Thank you, prison." He could pray those words because it was in prison that Solzhenitsyn found his soul. Hopefully, what has been said here has been transformative in that it has offered insight into the struggles with God, with family, and with self which those experiencing terminal illness face, in addition to offering assistance in the soul-searching.

Cancer did for me what prison did for Solzhenitsyn. My family and thousands of others experiencing the trials of terminal illness have used their experience as an opportunity to heal their souls and to strengthen their relationship with God. For this, I say "Thank you, cancer," and "Thank you, God."

BIBLIOGRAPHY

Acworth, Amanda, and Peter Bruggen. "Family Therapy when one Member is on the Death Bed." Journal of Family Therapy 7 (1985): 379-85.

Antonovsky, Aaron. "The Image of Four Diseases Held by the Urban Jewish Population of Israel." Journal of Chronic Disease 25 (1972): 375-84.

Bahnson, Claus Bahne. "Psychologic and Emotional Issues in Cancer: The Psychotherapeutic Care of the Cancer Patient." Seminars in Oncology 2 (December 1975): 293-308.

Baider, Lea, and Moshe Sarell. "Perceptions and Causal Attributions of Israeli Women with Breast Cancer Concerning Their Illness: The Effects of Ethnicity and Religiosity." Psychotherapy and Psychosomatics 39 (1983): 136-43.

Bard, Morton, and Ruth B. Dyk. "The Psychodynamic Significance of Beliefs Regarding the Cause of Serious Illness." Psychoanalytic Review 43 (1956): 146-62.

Bermann, Eric. Scapegoat: The Impact of Death-Fear on an American Family. Ann Arbor: University of Michigan Press, 1973.

Brody, Howard. Stories of Sickness. New Haven: Yale University Press, 1987.

Bruhn, J. G. "Effects of Chronic Illness on the Family." Journal of Family Practice 4 (1977): 1057-63.

Bulman, J., and C. Wortman. "Attributions of Blame and Coping in the 'Real World': Severe Accident Victims React to their Lot." Journal of Personality and Social Psychology 46 (1977): 877-91.

Burish, T.C., and L.A. Bradley. Coping with Chronic Illness: Research and Applications. New York: Academic Press, 1983.

Calhoun, Gerald J. Pastoral Companionship: Ministry with Seriously-Ill Persons and Their Families. New York: Paulist Press, 1986.

Cohen, Marie M. "In the Presence of Your Absence: The Treatment of Older Families with a Cancer Patient" Psychotherapy: Theory, Research and Practice 19 (Winter 1982): 453-60.

Cohen, Marie M., and David K. Wellisch. "Living in Limbo: Psychosocial Intervention in Families with a Cancer Patient." American Journal of Psychotherapy 32: 561-71.

Corsini, Raymond, ed. Encyclopedia of Psychology, 2cd ed. New York: John Wiley and Sons, 1994.

Cook, Judith A., and Dale W. Wimberley. "If I Should Die Before I Wake: Religious Commitment and Adjustment to the Death of a Child." Journal for the Scientific Study of Religion 22 (September 1983): 222-38.

Cooper, Burton. "When Modern Consciousness Happens to Good People: Revisiting Harold Kushner." Theology Today 48 (October 1991): 290-300.

Cooper, Sloan, et al. "Medical Students' Attitudes Toward Cancer." Journal of Medical Education 55 (1980): 434-39.

Christie-Seely, Janet, ed. Working with the Family in Primary Care: A Systems Approach to Health and Illness. New York: Praeger, 1984.

Curbow, Barbara, Roxanne M. Andrews, and T. Adam Burke. "Perceptions of the Cancer Patient: Causal Explanations and Personal Attributions." Journal of Psychosocial Oncology 4 (Spring/Summer 1986): 115-34.

Dalal, Ajit K., and Atul K. Singh. "Role of Causal and Recovery Beliefs in the Psychological Adjustment to a Chronic Disease." Psychology and Health 6 (February 1992): 193-203.

Derogatis, Leonard R. "The Psychosocial Adjustment to Illness Scale (Pais)." Journal of Psychosomatic Research 30 (1986): 77-91.

Ebigbo, P.O., J.O. Ojukwo, and S.O. Ukabam. "Family Therapy in the Management of a Dying Nigerian Cancer Patient." Joint Symposium of the European Working Group for Psychosomatic Cancer Research and the Kavetsky Institute for Oncology Problems. International Journal of Family Psychiatry 6 (1985): 83-95.

Ellens, J. Harold. "Toward a Theology of Illness." Journal

of Psychology and Christianity 3 (Winter 1984): 61-73.

Engelman, Suzanne R. "Clinical Approaches to Care of the Terminally Ill Family." International Journal of Psychosomatics 33 (1986): 48-50.

Erikson, Erik H. Identity: Youth and Crisis. New York: W.W. Norton, 1968.

Farley, Wendy. Tragic Vision and Divine Compassion: A Contemporary Theodicy. Louisville: Westminster, 1990.

Felton, B.J., and T.A. Revenson. "Coping with Chronic Illness: A Study of Illness Controllability and the Influence of Coping Strategies on Psychological Adjustment." Journal of Consulting and Clinical Psychology 52 (1984): 343-53.

Fintel, William A., and Gerald R. McDermott. A Medical and Spiritual Guide to Living with Cancer: A Complete Handbook for Patients and their Families. Dallas: Word Publishing, 1993.

Freidman, Stanford B., et al. "Behavioral Observations on Parents Anticipating the Death of a Child." Pediatrics 32 (1963): 610-25.

Friedrich, William N., and Donna R. Copeland. "Brief Family-Focused Intervention on the Pediatric Cancer Unit." Journal of Marital and Family Therapy 9 (July 1983): 293-98.

Frey, Joseph. "A Family/Systems Approach to Illness-Maintaining Behaviors in Chronically Ill Adolescence." Family Process 23: 251-60.

Galvin, Kathleen M., and Bernard J. Brommel. Family Communication: Cohesion and Change. New York: HarperCollins, 1991.

Gendler, Janet Ruth. The Book of Qualities. Berkeley, CA: Turquoise Mountain Publications, 1984.

Glasser, Paul H., and Lois Glasser, eds. Families in Crisis. New York: Harper and Row, 1970.

Goldberg, Stanley B. "Family Tasks and Reactions in the Crisis of Death." Social Casework (July 1973): 398-405.

Gotcher, J. Michael. "Interpersonal Communication and Psychosocial Adjustment." Journal of Psychosocial

Adjustment 10 (Fall 1992): 21-39.

Greer, S. "Psychological Response to Breast Cancer: Effect on Outcome." Lancet (October 1979): 785-87.

_____. "Psychological Response to Cancer and Survival." Psychological Medicine 21 (1991): 43-49.

_____. "Structural Family Therapy in Chronic Illness." Psychosomatics 28 (April 1987): 202-5.

Gruman, Jessie C., and Richard P. Sloan. "Disease as Justice: Perceptions of the Victims of Physical Illness." Basic and Applied Social Psychology 4 (1983): 39-46.

Hauerwas, Stanley. Naming the Silences: God, Medicine, and the Problem of Suffering. Grand Rapids, MI: Eerdmans, 1990.

_____. Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church. Notre Dame, IN: University of Notre Dame Press, 1986.

Hawkins, Don, Dan Koppersmith, and Ginger Koppersmith. When Cancer Comes: Mobilizing Physical, Emotional, and Spiritual Resources to Combat one of Life's Most Dreaded Diseases. Chicago: Moddy Press, 1993.

Hill, Reuben. Families Under Stress. New York: Harper and Row, 1949.

Holland, Jimmie, and Julia H. Rowland, eds. Handbook of Psychooncology: Psychological Care of the Patient with Cancer. New York: Oxford University Press, 1989.

Johnson, F. Leonard, Laura A. Rudolph, and John R. Hartmann. "Helping the Family Cope with Childhood Cancer." Psychosomatics 20 (April 1979): 241-51.

Katz, Ernest R., and Susan M. Jay. "Psychological Aspects of Cancer in Children, Adolescents, and their Families." Clinical Psychology Review 4 (1984): 525-42.

Kelley, H.H. Attribution in Social Interaction. Morristown, NJ: General Learning Press, 1971.

_____. "Attribution Theory in Social Psychology." In Nebraska Symposium on Motivation, David Levine, ed., 192-238. Lincoln, NE: University of Nebraska Press, 1967.

Klagsbrun, Francine. Mixed Feelings: Love, Hate, Rivalry,

and Reconciliation Among Brothers and Sisters. New York: Bantom, 1992.

Klagsbrun, Sam. "The Making of a Cancer Psychotherapist." Journal of Psychosocial Oncology 1 (Winter 1983): 55-60.

Klein, R.F., A. Dean., and M.D. Bogdonoff. "The Impact of Illness Upon the Spouse." Journal of Chronic Disease 20 (1976): 241-48.

Knudson, Alfred G., and Joseph M. Natterson. "Participation of Parents in the Care of their Fatally Ill Children." Pediatrics 26 (1960): 482-90.

Koch-Hattem, Alberta. "Families and Chronic Illness." In The Family Therapy Collections: Family Stress, James C. Hansen, ed., 33-50. Rockville, MD: Aspen Publications, 1987.

Koslowsky, Meni, and Sydney H. Croog. "Perceptions of the Etiology of Illness: Causal Attributions in a Heart Patient Population." Perceptual and Motor Skills 47 (1978): 475-85.

Kübler-Ross, Elisabeth. Death: The Final Stage of Growth. Englewood Cliffs, NJ: Prentice-Hall, 1975.

_____. On Death and Dying: What the Dying have to Teach Doctors, Nurses, Clergy, and their own Families. New York: Macmillan Publishing, 1969.

Kushner, Harold. When Bad Things Happens to Good People. New York: Avon Books, 1981.

_____. Who Needs God. New York: Summit Books, 1989.

Lalljee, Mansur, Laurence B. Brown, and Dennis Hilton. "The Relationship Between Images of God, Explanations for Failure to Do One's Duty to God, and Invoking God's Agency." Journal of Psychology and Theology 18 (1990): 166-73.

Lambrecht, Jan, and Raymond F. Collins, ed. God and Human Suffering. Louvain: Peeters Press, 1990.

Lavigne, John V., and Michael Ryan. "Psychologic Adjustment of Siblings of Children with Chronic Illness." Pediatrics 63 (April 1979): 616-26.

Lazarus, R., and S. Folkman. Stress, Appraisal and Coping. New York: Springer, 1984.

Lewis, Jerry M. How's Your Family?: A Guide to Identifying your Family's Strengths and Weaknesses. New York: Brunner/Mazel, 1989.

Linn, M., B. Linn, and S. Stein, "Beliefs About Causes of Cancer in Cancer Patients." Social Science and Medicine 16 (1982): 835-39.

Lowery, Barbara J., Barbara S. Jacobsen, and Joseph DuCette. "Causal Attribution, Control, and Adjustment to Breast Cancer." Journal of Psychosocial Oncology 10 (Fall 1993): 37-53.

Lupfer, Michael B., Karla F. Brock, and Stephen J. DePaola. "The Use of Secular and Religious Attributions to Explain Everyday Behavior." Journal for the Scientific Study of Religion 31 (December 1992): 486-503.

Macaskill, Ann, and James H. Monach. "Coping with Childhood Cancer: The Case for Long-Term Counselling Help for Patients and their Families." British Journal of Guidance and Counseling 18 (January 1990): 13-27.

Maes, John L. Suffering: A Caregiver's Guide. Nashville: Abingdon Press, 1990.

Mailick, Mildred. "The Impact of Severe Illness on the Individual and Family: An Overview." Social Work in Health Care 5 (Winter 1979): 117-28.

Mastrovito, René. "Cancer: Awareness and Denial." Clinical Bulletin 4 (1979): 142-46.

McCubbin, H.I., and J.M. Patterson. "The Family Stress Process: The Double ABCX Model of Adjustment and Adaptation." In Social Stress and the Family, H.I. McCubbin, M.B. Sussman and J.M. Patterson, eds. New York: Haworth Press, 1983.

Michela, John L., and Joanne V. Wood. "Causal Attributions in Health and Illness." In Advances in Cognitive-Behavioral Research and Therapy, Philip C. Kendall, ed., vol. 5, 179-235. Orlando: Academic Press, 1986.

Minuchin, Salvador. Families and Family Therapy. Cambridge, MA: Harvard University Press, 1974.

Minuchin, Salvador, L. Baker, and Bernice L. Rosman, et al. "A Conceptual Model of Psychosomatic Illness in Children: Family Organization and Family Therapy." Archives of General Psychiatry 32 (1975): 1031.

Niebuhr, H. Richard. The Responsible Self. New York: Harper and Row, 1963.

Parad, Howard J., ed. Crisis Intervention: Selected Readings. New York: Family Service Association of America, 1965.

Pargament, Kenneth, et al. "God Help Me: (I): Religious Coping Efforts as Predictors of the Outcomes to Significant Negative Life Events." American Journal of Community Psychology 18 (1990): 793-824.

Pargament, Kenneth I., and June Hahn. "God and the Just World: Causal and Coping Attributions to God in Health Situations." Journal for the Scientific Study of Religion 25 (June 1986): 193-207.

Piersma, Harry L. "The Family with a Chronically Ill Child." In The Family Therapy Collections: Health Promotion in Family Therapy, James C. Hansen, ed., 105-16. Rockville, MD: Aspen Publications, 1985.

Pillari, Vimala. Scapegoating in Families: Intergenerational Patterns of Physical and Emotional Abuse. New York: Brunner/Mazel, 1991.

Pollock, George H. "Childhood Sibling Loss: A Family Tragedy." In The Annual of Psychoanalysis, George H. Pollock, ed., vol. 14, 5-34. Madison, CT: International Universities Press, (1986).

Proudfoot, Wayne, and Phillip Shaver. "Attribution Theory and the Psychology of Religion." Journal for the Scientific Study of Religion 14 (1975): 317-30.

Pyszczynski, T.A., and J. Greenberg. "Role of Disconfirmed Expectations in the Instigation of Attributional Processing." Journal of Personality and Social Psychology 40 (1981): 31-38.

Rait, Douglas, and Marguerite Lederberg. "The Family of the Cancer Patient." In Handbook of Psychooncology: Psychological Care of the Patient with Cancer, Jimmie Holland and Julia H. Rowland, eds. New York: Oxford University Press, 1989.

Reid, D. "Participating Control and the Chronic Illness Adjustment Process." In Research with the Locus of Control Construct: Extensions and Limitations, H. Lefcourt, ed., 361-69. New York: Academic Press, 1984.

Reiss, David, Sandra Gonzalez, and Norman Kramer. "Family

Process, Chronic Illness, and Death: On the Weakness of Strong Bonds." Archives of General Psychiatry 43 (August 1986): 795-804.

Ritzema, Robert J. "Attribution to Supernatural Causation: An Important Component of Religious Commitment?" Journal of Psychology and Theology 7 (Winter 1979): 286-93.

Ritzema, Robert J., and Carole Young. "Causal Schemata and the Attribution of Supernatural Causality." Journal of Psychology and Theology 11 (1983): 36-43.

Roback, Howard B., ed. Helping Patients and their Families Cope with Medical Problems. San Francisco: Jossey-Bass Publishers, 1984.

Rolland, John S. "Toward a Psychosocial Typology of Chronic and Life-Threatening Illness." Family Systems Medicine 2 (Fall 1984): 245-62.

Sargent, John, and Ronald Liebman. "Childhood Chronic Illness: Issues for Psychotherapists." Community Mental Health Journal 21 (Winter 1985): 294-311.

Schuurman, Henry. "The Concept of a Strong Theodicy." Philosophy of Religion 27 (April 1990): 63-85.

Seaburn, David. "The Transgenerational Development of Chronic Illness Meanings." Family Systems Medicine 10 (Winter 1992): 385-94.

Seligman, Linda. Diagnosis and Treatment Planning in Counseling. New York: Human Sciences Press, 1986.

Sheinberg, Marcia. "The Family and Chronic Illness: A Treatment Diary." Family Systems Medicine 1 (Summer 1983): 26-36.

Simon, F.B., H. Stierlin, and L.C. Wynne. The Language of Family Therapy: A Systemic Vocabulary and Source Book. New York: Family Process Press, 1985.

Singer, Barton A. "Psychosocial Trauma, Defense Strategies and Treatment Considerations in Cancer Patients and Their Families." The American Journal of Family Therapy 11 (Fall 1983): 15-21.

Sobel, Harry J. Behavior Therapy in Terminal Care: A Humanistic Approach. Cambridge, MA: Ballinger Publishing, 1981.

Spilka, Bernard, and Greg Schmidt. "General Attribution Theory for the Psychology of Religion: The Influence of Event-Character on Attributions to God." Journal for the Scientific Study of Religion 22 (1983): 326-39.

Spilka, Bernard, Phillip Shaver, and Lee A. Kirkpatrick. "A General Attribution Theory for the Psychology of Religion." Journal for the Scientific Study of Religion 24 (1985): 1-20.

Springer, James R. "The Family with a Chronically Ill Adult." In The Family Therapy Collections: Health Promotion in Family Therapy, James C. Hansen, ed., 83-104. Rockville, MD: Aspen Publications, 1985.

Steinglass, Peter, and Mary E. Horan. "Families and Chronic Medical Illness." Journal of Psychotherapy and the Family 3 (1987): 127-42.

Surin, Kenneth. "Theodicy?" Harvard Theological Review 76 (April 1983): 225-47.

Taylor, Shelley E., Rosemary R. Lichtman, and Joanne V. Wood. "Attributions, Beliefs About Control, and Adjustment to Breast Cancer." Journal of Personality and Social Psychology 46 (March 1984): 489-502.

Timko, Christine and Ronnie Janoff-Bulman. "Attributions, Vulnerability, and Psychological Adjustment: The Case of Breast Cancer." Health Psychology 4 (1985): 561-44.

Travis, Georgia. Chronic Illness in Children: Its Impact on Child and Family. Stanford, CA: Stanford University Press, 1976.

Van Dongen-Melman, J.E.W.M., et al. "Coping with Childhood Cancer: A Conceptual View." Journal of Psychosocial Oncology 4 (Spring/Summer 1986): 147-61.

Viorst, Judith. Necessary Losses: The Loves, Dependencies and Impossible Expectations That All of Us Have to Give Up in Order to Grow. New York: Fawcett Gold Medal, 1986.

Vollman, Rita, Amy Ganzert, Lewis Picher, and W. Vail Williams. "The Reactions of Family Systems to Sudden and Unexpected Death." Omega 2 (1971): 101-6.

Watts, F.N. "Attributional Aspects of Medicine." In Attributions and Psychological Change, C. Antaki and C. Brewin, eds. London: Academic Press, 1982.

Weisman, A.D. On Dying and Denying: A Psychiatric Approach to Terminality. New York: Behavioral Publications, 1972.

Wellisch, David K. "On Stabilizing Families with an Unstable Illness: Helping Disturbed Families Cope with Cancer." In Family Therapy and Major Psychopathology, M.R. Lansky, ed. New York: Grune and Stratton, 1981.

Wellisch, David K., Michael B. Mosher, and Cheryle Van Scoy. "Management of Family Emotion Stress: Family Group Therapy in a Private Oncology Practice." International Journal of Group Psychotherapy 28 (1978): 225-31.

Westbrook, Mary T., and Lena A. Nordholm. "Reactions to Patients' Self- or Chance-Blaming Attributions for Illness Having Varying Life-style Involvement." Journal of Applied Social Psychology 16 (1986): 428-46.

Winder, Alvin E. "Family Therapy: A Necessary Part of the Cancer Patient's Care: A Multi-disciplinary Treatment Concept." Family Therapy 5 (1978): 151-61.

Winefield, Helen R., and Sandra J. Neuling. "Social Support, Counselling, and Cancer." British Journal of Guidance and Counselling 15 (January 1987): 6-16.

Wong, P.T.P., and B. Weiner. "When People Ask "Why" Questions and the Heuristics of Attributional Search." Journal of Personality and Social Psychology 40 (1981): 650-63.

Wuthnow, Robert, Kevin Christiano and John Kuzlowski. "Religion and Bereavement: A Conceptual Framework." Journal for the Scientific Study of Religion 19 (1980): 408-22.

Wynne, Lyman C., Cleveland G. Shields, and Mark I. Sirkin. "Illness, Family Theory, and Family Therapy: 1. Conceptual Issues." Family Process 31 (March 1992): 3-18.

VITA

Trisha L. Crissman was born January 22, 1966 in Grand Rapids, Michigan. She has an identical twin sister and one younger brother.

Trisha obtained her elementary and secondary education in the northwest suburbs of Chicago. From 1984 through 1988 she attended Loyola Marymount University in Los Angeles, and obtained her bachelor's degree in theology in May of 1988. From there she went on to graduate studies at Yale University, graduating in May of 1990 with a Master of Arts in Religion.

In June of 1990 she moved back to Chicago to rest before planning to go on for doctoral work in theology. At that time she was diagnosed with Hodgkin's Lymphoma, a rare cancer of the lymph system. She received treatment for her cancer through March of 1992, and began studies at Loyola University Chicago at the Institute of Pastoral Studies in Pastoral Counseling in September of that same year.

Trisha plans to begin work in pastoral counseling with cancer patients and their families upon her graduation in May of 1994.

APPROVAL SHEET

The thesis submitted by TRISHA LE CRISSMAN has been read and approved by the following committee:

Dr. ANN O'HARA-GRAFF, Director
Assistant Professor, Pastoral Studies, Loyola

Rev. ROBERT SEARS, S.J., Reader
Adjunct Professor, Pastoral Studies, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of MASTER OF ARTS IN PASTORAL COUNSELING.

4/12/94
Date

Director's Signature