



NEEDS OF THE FAMILY

The entire family is the unit of care. All members are to be treated as significant. Because of their varied needs and concerns, there may be a difference in priorities among members of the family and the dying person. The wishes of the dying person need to be considered first.

THE FAMILY NEEDS:

1. The helper to not be afraid of them. The caregiver will have to be grieving "well" his/her own losses to be comfortable with the ill person and the family. The family members will have fears and emotions that are similar to those of the one who is dying.
2. To be listened to so all the fears and grief-related emotions and reactions can be shared in a safe and compassionate environment, and to be responded to honestly, with accurate information shared clearly, simply and repetitively if necessary.
3. To be treated normally, to not be placated, treated with condescension or be over-protected.
4. To be involved in the care of the ill family member. They need to be consulted and given information the opportunity to make choices. This shows respect for all members of the family.
5. To withdraw from involvement with each other from time to time. Permission for this time needs to be given by caregivers because taking this time-out can engender guilt feelings in family members.
6. To be asked about specific needs or concerns, i.e., "What can we be doing for you that we are not now doing?" It is too easy to make assumptions about what a family might need, and these assumptions may be only partially correct.
7. The helper to give the impression that she knows what she is doing even if she is not completely sure. Such behaviour reassures the dying family; waffling will only enhance stress. It is always appropriate to reconsider one's position on an issue and make adjustments later.
8. To be free to choose "open awareness," "closed awareness" (denial), or "mutual pretense" when dealing with the reality of impending death. The ill person or family



may use various strategies to cope with the serious illness. Four criteria to keep in mind for such coping approaches to help determine whether they are functional or dysfunctional are:

- Are they predictable and appropriate at this time?
 - Do they safeguard the individual against incapacitating anxiety and depression
 - Do they enable the individual to maintain need-fulfilling relationships with the patient and/or other family members?
 - Do they interfere with the medical care of the patient?
9. To be allowed to focus on tasks that are of importance to the dying individual. Such tasks fall into at least four categories:
- to complete unfinished business
 - to deal with medical care needs
 - to allocate time and energy resources
 - to arrange for after death procedures and ceremonies
10. To be supported in a time of unsurpassed stress and to be respected and encouraged as they do their best to cope. To have hope supported as much as possible because hope sustains them through suffering. It is appropriate to encourage realistic hopes, i.e., short-term goals and day-to-day hope and expectations. Every individual deserves honest reassurances because maintaining a sense of realistic hope is crucial during the dying process.

The PROCESS of dying: some typical scenarios in families:

- Ignore or minimize the experience (denial).
- Fight it (alternate forms of medicine or treatment and visualization).
- Acceptance and participation (unfinished business and growth).
- Resignation (unfinished business/depression/peace).

Danger signs and behaviors that may indicate the need for extra or professional support with illness and/or bereavement:

- Avoidance
- Complete denial
- Increased alcohol or drug intake
- Severe depression
- Flight into activity



Family members at high risk during life-threatening illness:

- Young and married
- Those with dependent children
- Where the patient doesn't die "on schedule"
- Relationship difficulties
- Little or no social support