Capturing Death: Families of Children Recovering from Oncological Disease

Silvia Soccorsi, M.D., Flavia Lombardi, and Patrizia Rubbini Paglia

In the course of an investigation of 15 families with children suffering from oncological disease who are now in the process of recovery, the authors examine the organization of family adaptive mechanisms at three points in time: 1) the moment of diagnosis, 2) during the long medical treatment, and 3) during the gradual destructuring of these adaptive mechanisms in the recovery process. In order to formulate both the organization and the destructuring of these mechanisms, the authors take into account alteration of the time-space parameters, which "normally" define a family, in order to identify the various transformational processes that first led toward rigidity and the possible onset of psychiatric symptoms, and then toward flexibility and the normal resumption of the life cycle.

The present work grew out of eight years of research conducted at a day hospital for pediatric oncology.* The study is based on material drawn from the following sources:

1) meeting with parents, individually, in couples, and in groups;
2) direct observation of the young patients and their siblings in the playroom; and
3) stories and drawings, by the patients and their siblings, examined in chronological order.

Silvia Soccorsi, M.D., is Consultant Psychiatrist at the Department of Pediatric Oncology, Università Cattolica del Sacro Cuore, Rome. She also teaches at the Rome Institute of Family Therapy. Flavia Lombardi is Psychologist in the Psychiatric Service of the XX USL, Rome. Patrizia Rubbini Paglia is Occupational Therapist in the Department of Pediatric Oncology, Università Cattolica del Sacro Cuore, Rome.

*This work is a continuation of the research reported in *Terapia Familiare*, 1977, 2, 41–57.

Over the last two years we have extended our research to include families of children in the process of recovery. The whole family was invited to attend a session with the specified aim of research.* These sessions helped to clarify some of the interactional modes that we had previously observed in families with an oncological child and provided the principal basis for this article.

During the recovery process, we were able to trace gradual modifications in the rigidity of those family defense mechanisms that had been activated during the phase of illness, and to understand the reverse movement carried out by the family to reappropriate a temporal dimension that would revitalize its own cycle of development (2, 7, 15, 16, 17, 20).

FAMILY DEFENSE MECHANISMS

In his theory of the life cycle, Haley states, "Whatever the stage reached by the life cycle, the most important point for the development of the individual and his family is the point of transition to the next phase" (7). This transition takes place either through the efforts of single members of the family unit to modify relations between themselves, or else through a redistribution of roles that brings about new relations (for example, the birth of a child involves a redefinition of the husband's role as that of husband and father).

Transition constitutes a period of system vulnerability, in which generational boundaries may be crossed and symptoms may appear in one or more family members. As Haley describes it, "Symptoms appear when there is a deviation from, or an interruption of, the normal development of the family's life cycle . . . a symptom is the sign that family has to pass through one of the phases of this life cycle" (7). This theory provides a useful framework for identifying the mechanisms set in motion when the development of a family is strongly threatened by the arrival of a serious and uncontrollable event, such as the diagnosis of oncological disease.

From the moment the diagnosis of oncological disease is made, family defense mechanisms are activated in a desperate attempt to circumscribe or encapsulate this foreign body in the hope of neutralizing it (1, 2, 9, 14, 21). The family polarizes in a search for ways of reinforcing its defense cordon, and risks changing its principal objective from *living* to *surviving* (16). It could be said that the family's attempt to "control" the evolution of its own history is expressed in the need for inertia: The life cycle is blocked at the phase immediately preceding the onset of illness. In this way, the family is able to bear the illness and can *act* to cure it, concretizing it, and thus divesting it of the profound connected fear of death.

Consequently, rigid mechanisms are established, which seek to stem the flow of phases and crises characteristic of the development process. In order to bring development to a standstill, the family is forced to alter the relation

*We take the suspension of medication as the starting point of the recovery process. Twenty-five families were contacted; 15 accepted the invitation to a family session.

between the spatial and the temporal parameters that define it, losing all its dynamism in the process; space is static, time is negated. So development (life), which implies a succession of spatial and temporal modifications or relational modalities, becomes obstructed by the attempt to freeze relationships at their present state of evolution, creating the illusion that time itself is being halted (17). This mechanism, which forms the basis of every ritualization, allows the family to exercise strict control over its fear of the unknown (that is, its fear of death).

But in a system based on repetition there is no place for change (which is the essence of any life process); thus, the mechanisms deployed to avoid death guarantee that in a sense, death will become a reality. Nonetheless, the family can delude itself that it has in this way *captured death* and is, therefore, in control of its own destiny.

Through such *magic*, humans overcome this most ancient of mysteries and arrive at the *comprehension* of death, appropriating, embracing, and *living* it. If this situation is allowed to stabilize, a chronic condition will ensue; if, on the other hand, these mechanisms become aggravated, we are likely to see either a slow reverse movement toward change (where a degree of tolerance of separation-individuation may develop), or else the desire may emerge to translate the specter of death into death itself, whether violent or "natural."

Turning, then, to those defense mechanisms observed most frequently in families with an oncological child patient, we can isolate a first group characterized by an abnormal redistribution of roles within the family structure; and a second group characterized by radical modifications of family structure, which lead to the erosion of individual boundaries (4). The transition from one group to another takes place without any break in continuity between flexibility and rigidity, which define family relations, as the following figure illustrates.

Alteration of Family Structure Due to Abnormal Redistribution of Roles

In an attempt to contain the fear of death, the original family structure undergoes an initial phase of destructuring: spatial dynamism (which ensures vitality) becomes frozen, so interpersonal relations are reduced to rigid, static functions (23). Children's drawings are often clear representations of this destructuring.

For example, in one of her drawings, Bettina* divides her family into two subgroups: the mother-Betina pair, marked by bright colors and set against a background of distinct snowflakes; and the second subgroup, comprised of her father and two brothers, is drawn indistinctly, colorlessly, in a thick

*Bettina is a 14-year-old girl who was operated on eight years ago for a Wilms tumor. She is the youngest of three children. The father is a chemist, and the mother a housewife. Over these eight years the mother has dedicated much of her time to the parents association on oncological children, which coordinates the activity of the Day Hospital.

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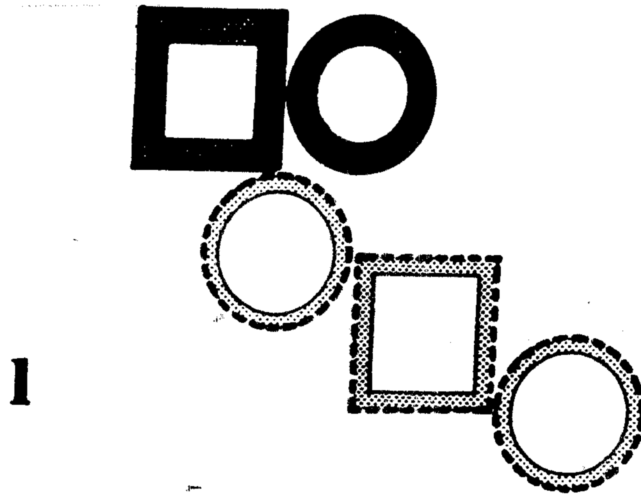

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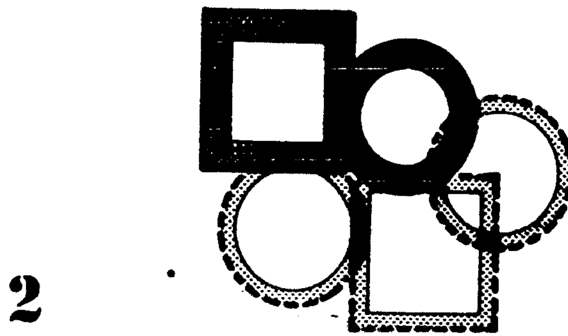

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Figure 1.

fog of opaque snow, which makes them difficult to identify. Such a picture explicitly depicts the functional roles previously codified by the family: mother and Bettina are *strong*, father *weak*, and the brothers *absent*. Beyond such an assignment of the reciprocal functions, we find the full-scale symptoms such as childish, adult, or orphaned behavior, which are manifested by the young patient as well as her brothers.

Limiting our discussion to the youngest generation, we find that these symptoms represent the most common strategies in the family's attempt to stabilize its life cycle. The following mechanism is the first and most elementary expression of an intense need for reciprocal protection: The child denies knowledge of his or her illness to avoid adding distress to the parents.

In assuming the burden of containing his or her parents' distress, the child takes on a protective function in relation to them, which in some senses shifts the child into the generational level of the grandparents.

This shift can be observed in two categories of behavior:

1) highly responsible behavior on the part of the child is constantly reinforced by the parents, and
2) regressive behavior by the child elicits the continual attention of the parents, so that natural movement toward new phases of development is interrupted.

Following is an extract transcript from a session in which Laura* "reveals" the presence of an imaginary companion who expresses the fulfillment of her need to (have parents in order to) be a daughter, or to contain the fear of death. Laura can only express this need by using a language in which childish and adult modes coexist:

Laura: I started to daydream because I missed a lot of days at school with this illness, and I didn't see my friends very often. So not having any friends, nor any brothers or sisters, *and of course not being able to talk to my parents about these things*, I started to create an imaginary companion who I could talk to about them. I often talk when I'm alone.

Therapist: But who is this companion? Another Laura?

Laura (laughing): No. She's an *imaginary* companion. I haven't even given her a name. . . . When I'm at home, I say, "OK then, you see . . . it's like this, or it's like that . . . you see." In fact, it's as if I were speaking to another person. I think she has my own mind and my own way of thinking, and she can have all the same ideas I have, but she's a little bit wiser than me. I mean, when I've got to make decisions. . . I turn to her and say, "Should I do this, or should I do that?"

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*Laura, 13 years old, was cured a year ago of acute lymphoblastic leukemia. She is still well, an only child in a family where the father is a company manager and the mother works for a political party. Both parents are active politically. At the time of the diagnosis they had applied for a legal separation, which they did not pursue. Later, Laura's parents underwent a multicouple psychotherapy course.

Therapist: And who gives the answer?

Laura: Oh, I suppose now that I think about it, when I make a decision I act as if she had told me what to do.

Father: I think there's something rather odd here: When you speak to us, you use a language that is restricted, really basic, even lexically deprived, you know? But when you speak to this person, do you speak to her in the same way?

Laura: Yes, I do.

Mother: You could try and introduce us to this person.

Father: So it's all spelled out in these few words, "This is a Laura I don't know at all."

A family's attempt to stabilize its life cycle most commonly manifests itself in adult or childish behavior in the young patient, while orphaned behavior was more frequently observed in the siblings. Following is a transcript of a family session when Alessandra is present with her sister Simona.*

Therapist: There's something I've noticed, Alessandra: When you speak, you lean against your mother or your father, as if you needed them to support you and surround you.

Mother: She likes to be prompted, because that way she can answer, she can speak.

Therapist: Would you like to draw a house for me on the blackboard? Well, that's pretty! Leukemia is keeping Mommy, Daddy, Fabrizio, and Simona inside this house. You are standing a little way off, with Grandma. I think this house hasn't really been your home for quite a while, because leukemia didn't care about you. So while Fabrizio and Simona had a box that was their house, you couldn't find one.

When you lean against your mother it's as though you were looking for a box, because I think you feel like those tiny dots you've drawn all spread out over the blackboard. If you wanted to get all the dots together, you would have to gather them all up and carry them very carefully into the box. Let's pretend that this box is your mother or your father, and that when you get near them, it's as though you wanted to go into the house, too. These dots are very pretty, they look like stars up in the night sky in summer, but the stars are a bit too far away! So you lean against your mother and you get to be less of a star in the sky and more of an Alessandra.

Alessandra replies analogically, putting the initials of all the members of her family inside the house she had drawn.

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*Simona was diagnosed six years ago with acute lymphoblastic leukemia and is now on the road to recovery. She is the second of three children. Her father is a caretaker of a school and her mother is a housewife.

Alterations in Family Structure that Affect the Boundaries of the Individual

As time passes, and the fear of death remains, the family may activate more rigid defensive strategies, leading to further modifications of spatial relations, and culminating in the erosion of the boundaries of the individual.

Loss of spatial parameters initiates a destructuring process that feeds the fusional tendencies within the whole family group. Relations are mediated exclusively in terms of the disease and the fear of death connected with it. From this point on the family expends all its energy in ensuring that this new pseudostructure remains static. To use a metaphor, the family's struggle against its fear of death is like the struggle of a boat's wooden boards against the elements: only one board need give way for the whole boat to sink.

In order to brace itself against the impending doom, the family calls upon its members, with ever increasing rigidity, to maintain the reciprocal fusion. But it is this same rigidity that transforms the family from a vital and dynamic organism into an inanimate and static entity. Fusion occurs when the family perceives that its defenses are not strong enough to save the ship from sinking, and any attempt to separate is felt to be a potential death sentence for the individual as well as for the rest of the family. In this sense, fusion is the expression of the high degree of protectiveness that binds the family together.

Protectiveness acts as a powerful homeostatic mechanism in the evolution of the life cycle because it tends to crystallize relations between individuals. We observe how the family, anticipating death in a vain attempt to avoid it, blocks the evolution of the life cycle, or limits its space, and paradoxically makes death a reality (17). To illustrate the analogies between the experience of negation of time and the concept of eternity, we can cite Mauro,* who asks himself every night on going to bed: "After death, I don't know how to explain it, how can you just go on and on living, without ever stopping? It's like another life that never ends."

For Mauro, eternity is the hope of making up lost time, time that has been negated for the six years since his tumor was diagnosed. However, the fear accompanying his nightly question expresses the difficulties inherent in this recuperation of time. The absolute necessity of protecting oneself from the evolution of the life cycle, which naturally leads toward death, determines the structural modifications that lead to fusion. This process depends on avoiding relational modalities that emphasize self-definition as an expression of individuality.

The relational model most commonly used by the family can be characterized as that of "let's pretend." We were surprised to discover this idea actually embodied in a story written by Marco.**

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*Mauro is a 12-year-old boy who nine years ago was operated on for a nephroblastoma and is still well. He is the youngest of four children. The father is a builder and the mother is a housewife.

**Marco is an eight-year-old boy suffering from acute lymphoblastic leukemia; he has been under treatment for two years. He is the youngest of four children in a family where the father is not regularly employed and the mother, a seamstress, maintains the family. During these last two years, they have had repeated problems with the antisocial behavior of their second youngest child.

> Luigi is happy, it's teatime and father tells everyone to dance. One brother pretends to play the guitar, the other one pretends to play the drums. It all seems very strange to Luigi, so he secretly goes to see what he can see and he finds a record player that works. But he decides to pretend he hasn't found it. Then they all drink a toast, and Mother realizes that he is only pretending, but instead of telling him, she goes on pretending herself. . . . They get home from the cinema, and Luigi can still remember the nasty scenes. He pretends that the sweets are sleeping pills and he eats five of them to make him sleep. Instead of sleeping, though, he goes on thinking about the thriller, as if he were having a nightmare. To stop himself from thinking about the film he watches cartoons through the movie camera his parents gave him as a present. After a bit, he falls down and goes to sleep and the movie camera goes off.

Here, "let's pretend" is expressed through a characteristic use of language that is both conversational and analogical. Spoken language represents one of the most powerful threats to fusion, since the "spoken word" may not easily be dispossessed of its meaning without defying logic. Neither is it easy to separate *who* is speaking from *what* is being said. It is above all the *word*—especially if this word is "leukemia" or "tumor"—that takes on enormous destructive potential. The family's efforts to avoid uttering the words are a necessary part of a ritual intended to exorcise their dangerous effects. The threatening aspect that the words pose in this context is linked to their function as mediators of interpersonal relations. The words would undermine the rigid mechanism of fusion, or "let's pretend," and as such are not to be tolerated (1, 3, 6).

Avoidance of the word may even lead to the coining of a series of private neologisms, as emerged from a session with Daniela's* family.

Therapist: Have you discussed Daniela's illness with her? I mean apart from platelets and red and white corpuscles?

Mother: No, to be honest. I think maybe the time has come to tell her about it, because I think she knows. Even if she doesn't say anything to me, she knows what it is, under a different name.

Daniela: Aneukemia.

Mother: That's the one. So I really think this is the time to tell her about it. Well maybe not, since we are worried that it might be traumatic for her. In fact, she's asked me, she said that on television they say you should always tell children the truth. I wasn't really sure. I said

*Daniela, a 13-year-old girl, was cured eight years ago of acute lymphoblastic leukemia and is still well. She is the second of three children. The father is a doctor and the mother works at home as a seamstress. The paternal grandparents live with the family.

to myself, "Let's wait until next time, when she puts it to me directly, then I will tell her."

Therapist: What's Daniela referring to?

Mother: Alukemia, she says she had alukemia.

Daniela: No, *aneukemia*.

Father: Aneukemia—with that word it seems you've joined two different terms together.

Therapist: So what does it mean?

Daniela: The lack of red corpuscles.

Therapist: A cross between "anemia" and "leukemia": *aneukemia.*

Daniela (laughing): Halfway between.

Mother: So that's it, you've made a cocktail!

Daniela: I don't like to say it.

Therapist: What?

Daniela: The word.

Therapist: You feel that way because you know they can't say it either. You're going to have to decide who will be the first to say it. That's the problem.

Little sister (pointing to her mother): Her.

While neologisms represent an attempt to negate the reality of illness through irrationality, rationalization represents the opposite extreme through which the family exercises control over its fear of death.

Therapist: I expect you sometimes thought you might die.

Bettina: I have thought I might die, but under other circumstances, not these.

Therapist: If you were to say here and now, in front of everyone, that you have often, or sometimes, been afraid of dying, there could be terrible consequences for the others. I think that's the reason why you can't remember it, or say it.

Bettina: But I really haven't felt that fear. If I'd felt it, I would have said so. Maybe a *doubt*, but not *fear*.

Therapist: What's the difference between doubt and fear?

Bettina: Fear is when you get worked up and say, "My God! This could happen to me. . . . I'll say a prayer here, and let's hope I don't die!" Doubt is when you say, "I suppose it just might happen," and you hardly even put it to yourself.

Therapist: Well done! You have a clear idea of the two aspects of the personality. In effect, the difference between fear and doubt is that doubt is a rational act, a knowing act; whereas fear is an emotional act. . . .

Bettina: That you can't control.

Therapist: Sure, that you can't control. With this distinction, you make it clear that you've always given a lot of space to rationality, to your faculty of reason, and that there is very little space for your emotions.

Bettina: It's better to be rational, then, later, one . . .
Therapist: It's better to be *one*.

We shall examine the mechanisms connected with the use of *analogical language*. We should first recall that whatever form the manipulation of spoken language takes, including its own negation in silence, one cannot invalidate a fundamental tenet of human communication: "One cannot *not* communicate."

There also exists a form of nonlexical communication that allows the transmission and reception of messages between individuals, willingly or otherwise. Mime, gestures, glances, crying, smiling, etc., are modes of communication that are inseparable from the meaning of things said or unsaid, and which define interpersonal relationships.

During a session with Rossella's* family, the daughters' total silence was in conspicuous contrast to both their mother's taciturnity and their father's verbosity. In fact, they appeared unable to express any experience at all. Rossella, who tends toward obesity, remained motionless in her seat throughout the session, with her coat buttoned up. There was a risk that her silence would make her into a "fortress of suffering."

Over the years, the fear of death may induce either a greater degree of flexibility, or an increase in the rigidity of defense mechanisms. During our research, we came across a number of drawings that represent the child's simultaneous collusive need to affirm and to deny both the fear of death and the desire for life (18, 19).

For example, Francesca** drew a series of "seven children all yellow and the same [twins] at home with Mommy," falling back on survival mechanisms proper to certain lower species such as fish, which produce a surplus of eggs in order to guarantee the survival of the species. Often the theme of death is linked to the position of the human body, lying down or "under the ground," its threatening aspect attenuated by vivid and colorful representation of nature rich in animal and vegetable life.

RECOVERY PHASE

We now turn our attention to tracing the evolution of the mechanisms described above during the period of transition from disease to full recovery (10, 13). Once medical treatment has ceased, the family faces a highly unusual situation. The fear of death, part of the closely woven fabric that binds the family together, must begin to make way for the claims to life. This

*Rossella, a 14-year-old girl, has been off therapy for two years after suffering a relapse of acute lymphoblastic leukemia at the end of a therapy cycle. The father is an electrician and the mother started work as a shop assistant after the disease was diagnosed.

**Francesca, a 7-year-old girl, was treated five years ago for acute lymphoblastic leukemia and is now on the road to recovery. She is an only child in a family where the father is a clerk and the mother is a housewife. The paternal grandmother underwent antiblastic therapy for a tumor at the same time as the girl, but has since died.

implies a gradual reconquest of free space, as total paralysis and the need to deny time give way to a search for the old, lost potential for movement, accompanied by continual uncertainty and astonishment.

The following passages, taken from family sessions, reveal the difficulty the family encounters as it reviews the various stages that led to the structuring of rigid defense mechanisms over the years.

Therapist: When you were ill, I expect, everyone was afraid you might die. But now, years after, because the treatment you've received was excellent, this fear has gone.

And so your disease no longer exists. However, it may be it still exists as a fear, as a memory of that period. The tumor no longer exists because it has been removed, but your fear of the tumor does still exist. You can rid yourself of the tumor but not of the fear. And it may well be that this fear still lives inside you and inside your father, your mother, and your brothers.

Also of interest for its related theme is this sequence, taken from another family session where Bettina talked about her tumor as "a tennis ball that I used to hold in my hands when I was little."

Therapist: What are you going to take away from this session?
Bettina: Take away or leave behind?
Therapist: Hey! She's bright, this kid! Let's say both.
Bettina: What I'm going to take away, I think, is knowing them a bit better, because to tell you the truth I didn't use to know them at all.
Therapist: That's what you'll take away, greater knowledge. And what will you leave behind?
Bettina: I'll leave a bit . . . well maybe I'll leave a bit of myself, a bit . . .
Therapist: You know what's just occurred to me? I think you're going to leave your tennis ball behind.
Bettina: Maybe . . . I mean really the ball . . . I don't know, maybe I've never had it with me, maybe I've still got it.

What seems to emerge from these examples is the family's tendency to maintain an acquired structure. It organizes itself even more rigidly around an experience of fear that is distributed equally among its members. Fear now replaces "leukemia" or "the tumor," which, in their concreteness (as "red corpuscles" or "tennis ball"), had been easier to represent and to localize in the child's body, and thus easier to control. The fear of death is diffuse and impalpable: It lingers like an aura of collective corruption, touching everyone. In the families we studied, we were able to observe a correlation between the rigidity of the family defense mechanisms and the resumption of an evolving life cycle during the initial phase of recovery. Our observations led us to the following considerations: In families where manipulation of

time-space parameters leads to the activation of defense mechanisms that transform the family structure through an abnormal redistribution of roles, the suspension of a course of treatment takes on a special significance. In fact, any medical therapy, with its related clinical controls, involves a system that divides time into regular periods in a ritualized manner. In families with an oncological patient, this aspect of reality takes on special value as a "rite," which can easily be utilized to keep the family's worst fantasies in check.

> "What is a rite"? asked the Little Prince.
> . . . and the fox said: "There is a rite, for example, among my hunters. Every Thursday they dance with the village girls. So Thursday is a wonderful day for me! I can take a walk as far as the vineyard. But if the hunters danced at just any time, every day would be like every other day, and I should never have any vacation at all" (12).

For these families, therefore, the suspension of medical treatments represents the loss of one of their most tried and tested defense mechanisms. The ritualization of medicine is defined, sanctioned, and perfectly complements the alteration of time-space relation common to all of the defense mechanisms activated in these families.

Reversal of parental roles, adult and orphanlike behavior, etc., are "hidden" mechanisms that lack official sanctions. But both ritualization and these latter forms fulfill the need to freeze space to negate time, and, ultimately, to keep the fear of death under control. Seen from this viewpoint, the suspension of a course of medicine may be a destabilizing influence that is powerful enough to reverse the homeostatic mechanisms that had previously ensured a blockage of the life cycle.

Father: We've experienced more because of this treatment, and we've even had a bit of crisis . . . with the release of tension, we've realized that something changed . . . in the sense that before, we were all involved in giving the medicine. . . . You felt a bit . . . then in the second phase the only thing to do wait and see if it would work or not.

In those families where the defense mechanisms tend toward fusion, the reactions are quite different. Here the crisis induced by the suspension of chemotherapy is not powerful enough to produce a destructuring that could lead to a gradual resumption of the life cycle. The affirmation of individuality has been repressed by the protracted and intolerable fear of death. As we have seen, the method used to avoid self-definition involves the abnormal use of both spoken and analogical language, so that any attempt to overcome the rigidity of the defense mechanisms becomes much more complex. In a few cases, the first opportunity grasped by the family to reverse some of the

mechanisms, which were set into motion by abnormal language use, was the invitation to a family session where silence could at last be broken. One may even suggest that acceptance of a family session could be used as a parameter for evaluating the degree of flexibility of the family's defense mechanisms. Their acceptance may indicate the possibility of experimenting with change in order to start out on the road back to health. In our experience, these families often give a positive evaluation of the session.

Therapist: What have you got out of this session, Antonio?
Antonio To see what my parents think. Even if I already knew.
Father: Officially.
Antonio: Officially. Before it was unofficially.
Therapist: Did you mind us talking about this today, Mrs. R.?
Mother: No, not all, I'm pleased . . . I think doing this, getting the family together once every so often . . . Well, I suppose they do things like that in the city, it's not something that exists for us in the country?

When we first started to study families in the process of recovery, we found it difficult to understand these positive evaluations of therapy sessions or the families' declaration that members had been able to talk about "certain things." Only in retrospect has it been possible for us to understand the destabilizing and, thus, potentially destructuring value of "finally speaking" or reappropriating spoken language as one of the most important media for interpersonal relation.

The families were starting out on the road back from fusion to differentiation to self-definition, from control over death to the resumption of the life cycle.*

STAFF INVOLVEMENT

We would like to offer a few observations concerning the pediatric medical team who share the fear of death with the family for the duration of treatment. The defense mechanisms described affect all of the family's systems. The people most often exposed to this type of empathy-fusion are the pediatric staff, who are constantly invested by the family with the power of fear-containment, which can develop into powerful demands for sympathy-identification. To comply with these implicit demands would reinforce those mechanisms that tend toward fusion. On the other hand, entering the emotional context in a way that avoids contamination by mechanisms of fusion allows a primary breakdown of rigidity to begin on various levels:

1) On the level of family structure, the staff member, by remaining outside

*These observations refer exclusively to families on the road to recovery. Other families may well face death due to a relapse or in the first phase of illness; or they may fall into a psychopathological course involving the onset of full-scale psychiatric symptoms.

of the fusional mass, allows the family to reexperience an interactive modality that had been abandoned, a modality that respects appropriate interactive spaces and generational boundaries.

2) At the level of the individual, boundaries that have been blurred by the family's tendency to overprotectiveness and fusion may be redefined.

Both the terms of relationships between pediatrician, family, and child and the capacity to change these relationships in time constitute an important element in the *prevention* of secondary psychological disorders (5, 8, 9, 11, 22).

We believe that specialized training is needed to teach medical staff the skills used in reading human relationships and in understanding how the self-other relationship is constructed, so the doctor-patient relationship, marked by a sharing of intense emotions and tensions over many years, does not come to reinforce processes of stabilization already set in motion by the family, and that it may instead serve to stimulate the evolution of the family life cycle.

This need is more relevant today because of the growing number of specialized treatment centers, which daily bring pediatricians face-to-face with the painful experience of children suffering. Working in a center for pediatric oncology means having a decisive impact upon serious pathology. However, this can involve a psychological risk for the pediatric staff members who, lacking adequate psychological preparation, activate their own defense mechanisms, which then integrate either positively or negatively with those of the family.

This article refers to a first stage of our research. At present, we are longitudinally reviewing some clinical material that gives interesting insight to the relationship between onset and course of oncologic illness and family interactions. This research might lead to interesting results both for planning prevention programs and for more precisely defining a model of intervention.

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Requests for reprints should be sent to Silvia Soccorsi, M.D., Viale Manzoni 26, 00185 Rome, Italy.