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Mourning is a Family Affair

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Dr.Gelcer deals with a variety of problems, including Depression, Anxiety Disorder, Phobia, Addiction, Burnout, Post Traumatic Stress, Gifted Children and Adults, Attention Deficit Disorder (ADD/HD) and Learning Disabilities (LD), Eating Disorder, Body Dysmorphic Dysorder (BDD), Bereavement and Loss. She is the author of articles on Family Therapy; Gifted Children; Bereavement and Loss; and Training and supervision of professionals and students. She is also the chief author and conceptualizer of the book “Milan Family Therapy”, which was translated to Japanese. Before opening her Private Practice in 1991, Dr. Gelcer was the Senior psychologist of the Child and Family Studies Centre in the Clarke Institute of Psychiatry, for over 13 years. During these years, she was also the Founder and Director of the Toronto Family Therapy Training Program, the Gifted Children’s Team and the Learning Disabilities Clinic.

Mourning Is a Family Affair

Mourning is a process of social disengagement. In our modern society, however, the influence of social and religious institutions on the process of mourning has significantly diminished and been partially replaced by mental health clinics. Given the latter's penchant for the intrapsychic view, the perspective on mourning has become reduced to the individual. These trends are clearly reflected in a review of current literature and research on mourning. This paper proposes an interactional, systemic view of mourning through the analysis of two different families. Findings indicate that despite contextual differences between these two families, some basic commonalities render generalizations possible: (a) The selection of the identified patient is not coincidental to the stage of the family life cycle and to the role of the deceased member in the system. (b) Although death affects each individual differently, depending upon his or her relationship with the deceased, it continues to influence all family relations with equal powers. (c) Nonresolution of mourning permits a ghost to become an integral member of the family system. Examination of the treatment process demonstrates that a systemic approach is effective, even when individuals are interviewed alone.

Three important elements of modern family life affect one's adjustment to dying and death. First, because of our current emphasis on health, adults and children may live for many years before a death in the immediate family occurs. This gap in life experience creates a crisis similar to most other family pathology. According to Fleck, "The absence of shared tragedy and mourning early in life has wrought

certain difficulties for families and individuals in facing death and gaining reassurance in the continuity of individual and family life after the loss of a loved one" (10, p.108).

The second element concerns the need to adjust to the phenomenon of dying. Because of improved medical services, death nowadays is not sudden but is expected and often occurs after a prolonged period of illness. This process requires a different adjustment than that for sudden death or chronic illness. Adjustment through anticipatory grief would normally be expected to result in gradual emotional disengagement by the various members of the family commensurate to the dying member's capacity for involvement with others. More often, for those inexperienced with death, there seems to be rather an increased emotional involvement with the dying member, and pathological family processes result resembling those of coping with chronic illness or with rearing a defective child.

The third element concerns the role of mourning in maintaining social and individual adjustment, especially the role of institutions in facilitating mourning for the preservation of equilibrium and social continuity (32, 35). Historical and anthropological studies indicate that every society, or culture, has had mechanisms for dealing with mourning. Usually these are governed by religious beliefs, which also dictate certain practices. These regulations emanate from an understanding of individual and interpersonal needs of mourners and at the same time are geared toward the preservation of social stability and growth (35). Our individualistic society has abandoned, or forgotten, many traditional social customs and religious rites. The role of religious and sociocultural institutions in bereavement has been diminishing along the same lines as in many other aspects of family life (e.g., marriage and parenthood). Our society presently offers little sociocultural support in cases of death. Consequently, it is perhaps not surprising that, of the institutions active in educating and in helping people deal with death and dying, mental health clinics are becoming prevalent. When individuals turn to these clinics for help, they are usually treated alone. Psychotherapy for unresolved grief reaction is still, by and large, based on Freudian psychoanalytic assumptions (13). Very little work has been accomplished based on systemic understanding and directed toward working with whole social systems. On the other hand, as the review of literature will indicate, studies of individual differences in relation to mourning are in abundance.

The main thrust of this paper is to demonstrate that "the work of mourning is best learned as a shared family experience" (10, pp.108-109); that is, regardless of social and cultural evolutions, death does not affect isolated individuals in any society and at any time, nor even isolated families. Death has a powerful impact on the beliefs that structure organizations, large and small, because it has implications for continuity, integrity, and change.

Two case studies will demonstrate, respectively, complications arising out of our inexperience with death and from anticipatory grief reaction. In both cases religion or sociocultural support was bypassed or intentionally ignored. Family malfunctioning eventually became apparent only a few years following an experience of death in each family. And although each presented an adolescent, individually, as suffering from behavioral disturbances, family pathology was clearly evident in the group as a whole.

More specifically, the struggles of these adolescents to begin adult life evidenced a parallel to their parents' attempts to establish new marital relations. The difficulties in each family were perpetuated by the omnipresence of a dead marital partner/parent. Until this dead person was psychologically buried and mourned, the role of a ghost colored all triangular relations and played havoc with each family member and the groups' accomplishments of their normal life cycle tasks.

Treatment focused at first on unraveling the connections between the adolescents' behavioral problems and their families' tendencies to avoid mourning. Once established, the thrust of the process of change

was focused on working with the parents on a monthly basis, allowing for time and for sociocultural reintegration of each family unit. This technique was primarily fashioned after the Milan team's (39) approach and incorporated features of structural family therapy tactics (28).

Literature Review

Studies of individual differences in mourning indicate that major discrepancies exist in individual reactions, depending not only upon the relative structural order or the label affixed to a social relationship or status, but more upon the intrinsic nature of a particular relationship that has been disturbed by death. For example, variations of such relationships include parent-child, child-parent, siblings, widow/widower, ages of the dead as compared with ages of survivors, etc. Individual reactions have been studied based on one or another classification of subjects. Thus, for example, it has been found that adults go through clearly delineated stages of mourning, the completion or disruption of which leads respectively either to resolution or complications (12, 25). Children, on the other hand, are far more limited than adults in their ability to conceptualize death (30, 2, 26), and this ability varies according to their age or cognitive level (37, 17). Children's expressions of grief therefore vary accordingly (14) but are also a clear function of the nature of their relationship with the dead (29, 14, 4), the circumstances of the death, and, in the case of a deceased parent, the sex of the parent and the ability of the surviving parent to provide a supportive environment for successful mourning (14). Helping children to cope with grief therefore seems to require a specialized approach. For example, because of children's difficulties in understanding death and verbalizing their grief, Leviton (22) among others, urgently points to the need for education about death, whereas Bernstein (5) suggests a bibliotherapeutic approach, and Berman (4) tailors a preventive mental health approach to facilitate mourning that takes into account the child's cognitive and emotional ability to comprehend death.

The literature also abundantly documents the problems children have as adults when they have not successfully mourned. These problems include such reactions as depression, difficulties with gender identity, various somatic complaints, and even psychosis. Adult problems related to unresolved mourning also vary, but whereas these reactions also seem to be related to the nature of the relationship with the dead person, support systems available, circumstances of death, etc., adults are generally taken to have better coping skills than children.

Anticipatory grief is given special attention in the literature because of its effects on the mourning process. This reaction, experienced generally upon forewarning of loss, confounds grief by virtue of the protracted period of dying. Again, studies have focused primarily on individual adult's reactions to the prolonged illness of a spouse or of a child. Ball (3), for example, found that reactions to sudden death were overall more intense than to prolonged illness of a spouse for survivors below 45 years old, whereas sudden death was less significant for older survivors. Parkes (31), on the other hand, found that anticipatory grief increased the chances for good adjustment in young widows and widowers. Glick et al. (15) advance the notion that anticipatory grief provides a chance to give up (false) hope and to understand the cause of death.

Although some links between anticipatory grief and mourning have been established, results are inconclusive and operational definitions are muddled (13).

The arguments about the effects of anticipatory grief have not yet been extended to studies of children. Knowledge of developmental psychology, however, indicates that anticipations are cognitively complex functions of which young children are mostly incapable (34). So much more true for anticipation of death.

Whereas researchers and clinicians seem to have taken the easy (but unproductive) route of studying one unit of the family structure at a time�usually the older the better�rather than tackling the whole system, studies of children's reactions to death perhaps highlight the importance of the family and larger social systems for providing education and support during the mourning process. Fulton and Gottesman (13) argue that "the difficulty with the traditional psychoanalytic perspectives of grief is that they are based on the assumptions about human reactions to loss that fail to give due consideration to either the socio-psychological, or the socio-cultural aspects of the phenonema" (3, p.50). They criticize demographic research in this area as guided by two basic assumptions: (a) that all subjects in a particular state of mourning experience comparable volumes of grief, and (b) that the mourning process, once begun, continues in an irreversible path of dissipating grief. They emphasize again that "grief is not a private matter" (13, p.51). Others have highlighted the contextual significance of mourning by finding that the expression of grief is contingent on the psychological significance of persons in the family (36) and upon that family's capacity to deal with, or to deny, death (40).

Assuming these psychosocial considerations and given the dwindling role of active cultural and religious mechanisms, psychotherapy seems to have become the primary mode of helping mourners. In family therapy, for example, analysis of the sociocultural context in which mourning is unresolved usually reveals that a close relationship exists between the behavior of the identified patient and the role of the deceased member in the family life cycle. One is a living monument to the loss of the other. Similarly, as long as the deceased member's role is maintained alive in the family, other members' roles are rendered dead or inactive; progress in the accomplishment of family life cycle tasks is arrested.

Caplan (9) considers that the stoic family member who is credited with being "courageous" and "strong" for not crying over a lost loved one is headed for trouble. Yet, today, to be "superman" is still more acceptable than to give in to expressions of pain. Grief applies to everyday situations, affecting and being affected by those people who survive. The reciprocal interplay between mourners and their social support systems ideally leads to maturation and to learning to give up what is obsolete, to assume new roles and to take on new life tasks. The ill effects of bypassing mourning, however, evolve into family and social pathology. On the other hand, reactions to death are like reactions to crises or illness. They can be viewed as having their own mobilizing effects on the individual and on the family.

Caplan (9) suggests minimizing interventions in order to modify as little as possible the impact of hazardous life situations on the family and on its members' way of dealing with those situations through their own efforts. Along the same lines, MacGregor's (27) Multiple Impact Therapy (MIT) deals with the process of mourning within a family context and on a brief intervention basis. This technique is interesting in that it considers the limitations of individual members in a family as well as implies a thorough understanding of the whole system. The MIT method basically involves helping the natural love object, or the spouse, to be more satisfying than, for example, the heretofore exploited child. They help the widowed mother "to seek the adult satisfactions of continuing growth in preference to encumbering her child by 'living for him'" (27, p.160). Based on Bowen's astute systemic observation that emotional closeness or distance between the parents directly affects the treatment results of children (8), the MIT project's attitude is one of keen attention to the parents. This is based on the thinking that in times of stress, illness, or death in a family, the parents need attention. Therefore, the MIT team would communicate to parents its belief that they and the family system as a whole would derive direct benefits from doing something constructive for themselves and their children.

The MIT approach is strikingly similar to that which is practiced by other experienced family therapists such as the Milan team (38). The latter, however, focus on the paradoxical nature of unresolved crises in families. These therapists struggle to tailor paradoxical prescriptions suitable to each family in its context.

In our examples of unresolved grief, the striking paradox that emerges is that the dead are regarded as living and the living are viewed as dead. Ritualized prescriptions can accordingly incorporate a paradoxical injunction in such a manner as to bury the dead or revive the living. This is no substitute for religious rites, of course. If applied accurately, however, it can have a powerful impact on the evolution of change while preserving family unity.

Recent developments in family therapy, especially the latest method developed by Selvini-Palazzoli and Prata,1 clearly emphasize not only that the parents are the pivotal point of the family system, but also that clinical interventions with this holon are tantamount to affecting the nodal point of the system. In addition, although the actual treatment techniques of The Milan team differ from the MIT project, there are significant similarities. All are guided primarily by three therapeutic principles: team approach to therapy, brief intervention model, and relatively long intervals between sessions.

These principles, together with strategic-systemic reasoning, also guided the work with the families presented here. At that time I had already visited Selvini-Palazzoli and Prata in Milan and was influenced by their new work. The treatment of the families, therefore, combined the influences of past experience with similar problems, together with the application of new approaches, including some principles of structural family therapy (28). The two cases, in sequence, show the evolution of the ideas and the work.

Case Presentation

Family A

Melissa was 13 years old. Her mother, a famous literary personality, died mysteriously from a "freak accident" at home when Melissa was 6 years old and her sister, Heather, was 2 years old. The father, an executive in a large firm, gave up his work for a year in order to tend to his young daughters. By the end of that year he fell in love with, and married, a young previously unmarried woman, who one year later bore him a son, Jerry. This woman was proud to be chosen to succeed the famous deceased wife. Although she knew that she could never live up to the dead woman's fame, she was confident of surpassing her in her own capacity to love and care for her husband, his children, and their son. She was an immaculate housekeeper. Her husband reciprocated by acknowledging his love for her�emotions he said he hadn't experienced in his previous marriage�and by shifting his Bohemian life-style to one oriented toward home and family. All three children grew up doing well at school and having harmonious relations at home. Because of the girls' youth when their mother died, they were considered to have forgotten about her or never really to have known her. Like Jerry, they addressed the new wife as mother and expected to receive the love and affection that was showered on Jerry by both parents. Heather succeeded better than Melissa in this, as she emulated her (step-) mother's behavior, including spoiling the father.

Early in her adolescence, Melissa was taken to a therapist because she was described as defiant, lazy, skipping days at school, having failed a class in the previous year, and, in the (step-) mother's words, "endangering the peace at home." "Heather loves her so much and may begin to imitate her." Melissa was diagnosed as severely depressed and borderline psychotic; the family was referred for family therapy.

Melissa's appearance was striking. She looked much older than her stated age, except for a baby-like, naïve, sad look in her eyes. She was tall, fully developed, and well dressed. In the presence of her family she was more withdrawn and depressed than when she was seen alone. But even in individual sessions she spoke inaudibly, if at all. At home she was reported to maintain a similar silence while she continued to do as she wished: coming home later and later every night, getting up late, skipping school, and avoiding all family activities and chores. Her father was full of rage as he reported that he was impotent to discipline the girl. She behaved and looked like the "zombie" her (biological) mother looked like,

according to the father, except that the mother produced intellectual works of fame, whereas this one "will be unalphabetic" Her stepmother (Melissa now refused to call her "mother") expressed a wish to help Melissa but more out of protection of her husband ("he smokes and drinks too much when she upsets him") than out of compassion for the teenager. She said that she found it difficult to mother Melissa when the child refused to call her "mother."

It soon became apparent that the work of mourning the dead mother was not resolved, if at all begun. At the same time, the new marriage was not yet acknowledged. This was expressed in the family's system of attitudes and beliefs, which included two mother-wife figures. The one that was presumably part of the past was still present in the lives of all family members and provoked intense reactions. The new wife-mother's role therefore was a countermeasure to the intrusive ghost of the dead wife-mother. Both were maintained at all costs. The competition between the two wife-mothers produced a situation in which alternatives existed for different parts of the family; for example, a "bad" wife could be idealized as a "good" mother, and vice versa. But at this point of the family's history, the living wife-mother felt she was losing the battle for her role because it was not recognized by the whole family. Who can fight a ghost? Resolution of the past, and integration of the present reality was necessary.

The couple were invited for therapy sessions without the children in order to help them cooperate better with each other as a married couple and in taking care of the children. This move also differentiated the present from the past and the parental issues from those of the younger generation. The reaction to the invitation was mixed. Mother: "We have never had a honeymoon. Ever since the day we were married I have been treated as the 'best housekeeper' for this man and his children." Father: "I suffered enough in my previous marriage. Her death was a relief. This woman I love. She is an excellent wife. We don't need marital therapy." At the same time both parents agreed that neither of the younger two children needed treatment and Melissa's individual treatment was not helping anyone much.

This agreement between them, to remain ambivalent about treatment, confirmed the fact that mourning work was premature at this point. Therefore, therapy continued to focus on the functions of this couple at home and outside. The parents' ambivalence, however, was directly expressed in the children's behavior at home. When the parents cooperated (not only at home, but also in playing tennis, going out more, etc.), Melissa and her father became closer. He disciplined Melissa and was able to differentiate her from his dead wife. But the mention of the dead wife's name was taboo, at home and in therapy (unless it was used derogatorily). The change in the father-daughter relationship became threatening to the new wife, who felt that, if her husband succeeded better than she with Melissa, her own work with the girl would be superfluous. In spite of all she had done, she was not the real mother, whereas he was the real father! As the wife's negative reactions to Melissa intensified, Heather aligned herself with her sister and father. Melissa began taking drugs, and Heather formed a secret coalition with her. As this symmetrical escalation proceeded, the husband was caught in the middle. He was now faced with two alternatives: the possible loss of his (second) wife or of his two daughters; (mother: "I told you she would corrupt Heather!"). The father chose a third alternative: Melissa was sent to see a psychoanalyst who found her uncooperative and referred her for treatment in a private institution out of the country.

The maternal grandparents, who in earlier years served to preserve their daughter's memory by introducing Melissa to her mother's works, now became disillusioned with their hopes for the girl and made a substantial financial contribution for her institutionalization. Both Mr. and Mrs. A felt it was right that these grandparents should be "punished" in this manner for their intrusions into the couple's life and heaved a sigh of relief that they could now live in harmony with their "perfect" son and daughter (one from each marriage). They considered this to be a better solution to the problem, since it was "Melissa's

problem to begin with." They couldn't see that mourning, seven years later, was called for. So they stopped coming for treatment.

But as Melissa cooperated fully and quietly with her removal from home, Jerry's and Heather's social, academic and disciplinary problems intensified. These reactions both surprised and dismayed the parents, especially the mother. She telephoned asking for an individual session and explained that she was now feeling "an absolute and utter failure." She could not help her children alone. Her husband resumed drinking, she thought, because "he is now mourning the loss of his daughter." As she introduced the issue of mourning, the couple were invited back for therapy; that is when mourning work was accomplished, at first indirectly and involving one member of the couple at a time, but gradually more directly. Although only the couple participated in treatment, the effects of the work seemed to touch the whole family, including the maternal and paternal grandparents.

What convinced me that mourning work was called for, despite the parents' denial, was that the ghost of the dead wife was brought up at the most unexpected times and in a surprising fashion. For example, in Melissa's absence, her stepmother began tidying and reorganizing her room. She then moved into Melissa's room a large oil painting, a portrait of the dead wife, which was apparently considered a great piece of art and had hung in the entrance to the family's home. Mr. A considered this move "a waste of an art work," an intrusion on Melissa's privacy in her absence, and a contravention of his authority, since he wasn't consulted ahead of time. Heather also reacted negatively, feeling left out of memorabilia of her mother; and even little Jerry complained that "there are too many changes at home." The maternal grandparents soon heard of this move and expressed their own wish to possess their daughter's portrait.

It became clear that this ghost lived for seven years because it had many allies in the family, while her replacement was moved in swiftly and singlehandedly by the father in order "not to change anything in the lives of the young girls." It was this realization that prompted me to emphasize the many drastic and negative changes that had befallen the family: Their love for each other was jeopardized by a ghost they would all rather bury; a promising daughter was removed to an institution; another was perhaps heading in the same direction; a son�who "has nothing to do with it at all"�was also beginning to fall behind; and now, a loved second wife was feeling useless and on her way out.

The solution was intuitive and simple. The couple were to build a "new home" for themselves. Children and grandparents must have no part in this decision. Therefore, Mr. and Mrs. A announced to the children that while they were away at summer camp, the parents would be working hard to renovate the home or look for a new one. The couple were then asked to go through the whole house, room by room, and check each and every piece of furniture; whatever both liked would remain, whereas anything that either one of them objected to (this would be mostly the wife, because she claimed her wedding gifts "were still in their original packages in the basement") was to be sold or placed in the basement. Only after the cleaning of the old was completed and "empty spots" perceived could they break open the packages of their wedding gifts and arrange the new order.

The wife was eager to perform the task, but the husband acquiesced reluctantly, feeling pressured to preserve his wife's sanity. Both agreed that they would rather build the new marriage than mourn the old. But upon the husband's first excursion to the basement, loaded with "articles unwanted" by his wife, he did not emerge again for the rest of the day. His wife continued rearranging the upstairs, unaware of the passing time, but eventually she became concerned about her husband's absence and went to the basement herself, carrying more rejected articles. She was astonished to find him knee deep in the books, diary, and photo albums of his previous wife. He claimed he was "making space for things," but she was upset. She had discovered that the ghost had its own quarters and that they occupied a substantial part of their home.

Both realized then that they were trying to build a new and growing relationship upon monumental ruins of the past. They suggested a reciprocal division of labor�he clean up the basement while she rearrange the upstairs. This atmosphere of trust and cooperation allowed the couple to make sensible decisions and to unite against oppositions from others. They donated most of the dead wife's works to libraries, sold some of the art work, and bought new works selected by both. In the absence of their children, they paced their housework with common holidays and with the development of their individual talents (the wife began pottery classes and the husband began writing short stories). When the children returned, including Melissa who gradually rejoined the family, they were faced with a congruent, cooperative, and enterprising couple.

Family B

Larry was 13 years old. He was referred for treatment by his mother's cousin who was in the helping professions and who explained that she could speak better English than Larry's immigrant mother. But a conversation with Larry's mother revealed not only that the latter was fluent in English�although with a heavy accent�but also that she had taken Larry to an ethnic psychiatrist three years previously when his father was dying of a prolonged and rapidly deteriorating illness. At that time she presented Larry's problems as "absent-minded and falling behind in school." The psychiatrist's diagnosis: "transient situational reaction." Recommendations: individual therapy for Larry with additional treatment for his mother. Shortly thereafter, the father died, so neither Larry nor his mother followed the recommendations. Three years later they returned to the same psychiatrist, escorted by the cousin, who complained that Larry was getting worse. He was lying, shoplifting, daydreaming, and failing at school. This time the diagnosis changed to "borderline psychotic reaction," as Larry presented behaviors colored by feelings of omnipotence, unrealistic fears of murderers and drunk people, and beliefs in magic. The family were referred to our Centre for family therapy.

Mother; her common-law husband, Peter; Larry; and his younger brother, Marco, 7 years old, were invited for a family assessment. All came except Peter. A slip of the tongue in the first session, made by Larry's younger brother, Marco, indicated the confusion in this family about their adult roles. I began the sessions by asking the ages of the family members present. Marco said, "But my father is not here today. Whose age do you want? My real father's or the one who is not here or only my mother's?"

All three adults did not vary much in age: 32 to 35 years. But Marco, unprovoked, proceeded to calculate, with great difficulty, what these adults' ages were at the time of his father's death, three years past. Despite the fact that Peter only recently joined the family and was absent from the first session, for Marco time had stood still. Events were relevant only in relation to the time of his father's death.

The mother immediately took over, informing us that Marco "didn't know anything because he was only a baby then"; (he was 4 years old when his father died). The real problem, she said, was Larry, because now she was ready to marry Peter, but Larry was objecting to the marriage:"He doesn't like Peter, he won't listen to him and won't call him 'father,' unlike Marco."She was afraid that Marco would soon begin to emulate his brother and that this would increase the opposition to the new marriage. She vehemently protected her common-law husband's absence from the session, claiming he was "working hard to support the family."

The team, having gauged this confusion in the family system, decided to support Peter's absence and to inquire about the father's death. The mother's insistence on telling the story in detail and her apparent pleading with the children for forgiveness and compassion indicated further the unresolved grief and delayed mourning.

Shortly after they were married the couple had immigrated to Canada. The husband, a truck driver, often complained of fatigue, but he was known to be a loving man who was eager to succeed. Six years later he fell off his truck, suffering some fractures, and never recovered fully. During this period he spoiled Larry a great deal and told his wife that they should have another child soon. Shortly after Marco's birth the father became disabled and unemployed. The wife sought full-time employment in order to provide for the family, and Larry, then at the beginning of elementary school, cooperated by baby-sitting for his brother and caring for his ailing father. Both children recalled that period in their lives, but mother compulsively continued her story.

When she was told of her husband's imminent death, she sent her children to her parents overseas. She said she began mourning him prior to his death. She had cried for him all that summer while she worked and visited him in the hospital. The day prior to his death she was planning to go on a picnic because she felt that she had cried enough by then. Her husband agreed that she needed to get away a little, but he also told her of a dream in which he was reunited with the children. She read his message as requesting family closeness, canceled the picnic, and stayed by his side until he died later that day. She then telephoned her parents announcing his death and asking them not to divulge the news to the children. Since she expected them back at the end of the summer, she preferred to tell them herself. Nevertheless, Larry clearly recalled."I was so confused! Everyone was wearing black! I asked my grandma�she said her sister died. I asked my grandpa�he said his brother died. But I didn't see any funeral!"

The paternal uncle took photographs of the funeral from which the mother prepared an album to show to her children when they returned. But they had not yet seen it at the time of assessment. Instead, when the children returned home and were eager to see their father, their mother sat them down and said, "Your father died. That's it. There are only the three of us now." Larry and his mother cried while he told her: "You must get a new husband now, more, quick!" His mother responded, "No, you will be the man in our family, Larry."

She refused to wear black for a whole year (as required by her ethnic custom), as she claimed to have suffered and mourned her husband enough. In addition, she discovered after his death that his family had known all along of his terminal condition and that was the reason behind their hitherto unexplained objection to the marriage. Angered by this discovery and by her misfortune, she refused to practice any religious rites. This prompted her younger sister, whom she had nurtured and loved dearly, to sever all ties with her. Having severed ties with the husband's brother, the family was left without any support.

Larry's problems began with psychosomatic complaints and went on to shoplifting, stealing, showing phobic reactions, and attracting attention at school by being the class clown and a failure. The union with Peter brought relief to the family budget and a welcome support for Larry and Marco, but the honeymoon did not last long.

Although Peter appeared for some of the family sessions, his presence and absence soon came to represent his tenuous position in the family and his own depression about unresolved ties with his own ex-wife and children. Separated five years ago, he was not allowed to see or have any contact with his own two children, the youngest of whom was just born at the time of the separation. Furthermore his ex-wife vengefully refused to divorce him, so he was forced to wait two or more years (in total, seven years) before he would be eligible to marry again. Peter was also showing phobic reactions. For example, he wouldn't drive a car, thus placing his common-law wife in the role of his chauffeur. He worked seven days a week and was always too tired to do anything but watch TV.

According to the team's assessment, the family were told that they were "trying too hard and too fast to become a family again. In these efforts you seem to become so confused that you behave as if the dead father were alive and the living father were dead."But since the children were considered too young to sort out this confusion right now, only the couple were invited for succeeding sessions. Peter again dropped out temporarily but indirectly made his presence known through phone messages. Nevertheless, the team conceptualized the mother's appearance for sessions as her being not alone. She was appearing, without Peter, as a "representative" of the past marriage.

Four sessions with the mother alone focused at first on helping her structure and monitor the children's behavior according to the principles of the past marriage, as the only surviving parent. In the third session she appeared dressed in a black dress (in mid-summer): "Larry bought it for me at Christmas with money he received from Peter." The message could not be ignored. We reviewed her mourning rites. To our surprise, she informed us that recently she happened to show the children the burial album of their father for the first time. She cried a great deal during this session, realizing the connection between her unresolved grief and her dress, the connections among Larry, Peter, and her deceased husband. What could she do now?

We said that although we could help the surviving family, we could not intervene with the dead. "Perhaps the church would have an answer." Since we recognized that this period was particularly difficult for her, we offered extra sessions in addition to the monthly routine. She didn't utilize these. She returned for the fourth session angry with her sister and with the latter's lack of support. She also talked of her parents' refusal to acknowledge her widowhood. Indirectly, however, she also indicated some progress. Whereas in past years she visited the grave every weekend, taking the children (and later also Peter), this year she went alone and only in order to plant flowers. She did not intend to return to the grave for the remainder of the year. Sensing her need for broader support, but recognizing her problems in getting this from her family of origin, we reiterated our previous prescription, adding that perhaps there were still some rites she had overlooked that the church would indicate and help her with. "Our team is limited in regard to religion," we said.

She did not return to the following sessions. Instead, it was Peter who called in the winter, saying that he might "leave her if she doesn't change." The couple were invited back, and this time Peter reported that he was feeling alienated from the family: "Perhaps I should have some sessions alone with you, like my wife had." She agreed. She pointed out that Larry was progressing well at school, that he had a girlfriend, and that "perhaps Peter is jealous because he isn't having as much fun as Larry." Our focus and our next step was to work with "the living couple."They cooperated.

During the couple's sessions we realized their deadlock. Peter wanted new children in this marriage, but she had had a tubectomy (instructed by her dying husband, after Marco's birth, to have no more children). She, on the other hand, accused Peter of stalling his divorce proceedings, although she knew his ex-wife's role in that. Consequently, she refused to consider allowing Peter's children in her home, and Peter did not fulfill his promise to be a father to her own children. The deadlock was soon felt by the children. Marco's teachers complained of his deterioration at school, and Larry threatened to leave home. In the meantime, Larry sought a part-time job helping a truck driver. A crisis occurred when Larry returned home from a truck excursion at 3:00 A.M. He claimed they had had mechanical failure. His mother didn't believe him, and Peter got into a fist-fight with him.

At this point, the team advised the whole family to return to family therapy. It was reasoned that the mourning work by the mother and her children was completed and that the focus should now be on reinforcing the present family structure. Peter was commended for showing how much he cared for Larry.

Instead of emphasizing his impotence in parenting his own children, his wishes to parent Larry and Marco were encouraged. Larry dramatically heaved a sigh of relief and begged his mother to "stay out and let 'us men' tackle it." They did so to the best of their abilities.

Discussion

The scope of this paper does not permit comparison of these two cases with more similar cases, with individual treatment of similar problems, or with similar treatment of different family problems. Inferences can be drawn from comparison with the reader's experiences or with cases reported in the literature. The paper is an attempt to provide as detailed a description as possible of each family process in its unique context, sacrificing breadth for depth of presentation. In doing so, the difficult task is to highlight the unique features of each case in terms of problem presentation and treatment process, at the same time underlining their common denominator.

To summarize, Family A was Anglo-Saxon, Canadian born, and upper middle-class, from a well-established background. The family encountered a sudden, unexpected death of a mother who, while alive, was considered distant from her children (they were cared for by a nanny) and incompetent as a wife. Nevertheless, she left a legacy of professional accomplishment and fame. The surviving husband remarried relatively soon after her death. The new marriage brought a competent mother and wife into the home and subsequently produced another child in the family. Problems began to be noticed only seven years later. The identified patient was a girl.

Family B, in contrast, was from a lower middle-class, Greek-immigrant background. In this family, a father, not a mother, had died. Although his death was considered unexpected by the children, both parents knew of its inevitable occurrence, and the children were subjected to abnormal hardships in the process. Anticipatory grief was reported by the mother. Although the children's developmental tasks were compromised in the face of their father's prolonged terminal illness, they became very attached to him as they nursed him at home.

In this family, the mother reported a loving, close, and cooperative marital relationship. Her anticipatory grief, however, mixed with sociocultural factors, clearly influenced all family members. In addition, immigration and acculturation pressures, followed by the father's inevitable unemployment, contributed to the general mood of depression and to the unstructuring of roles in the family. Reactions of this nuclear family following the death of the father were in marked contrast to the extended family's reactions and to those of their ethnic/religious group. Whereas all others mourned him and followed the rites fully, the mother thought that she and the children had suffered enough and refused to participate in Greek Orthodox rituals. Instead, the nuclear family, who bypassed religious rites, traveled every weekend to visit the father's grave. For them he was a recreational object. Eventually, when the maternal aunt introduced Peter to her sister three years later, only an informal marriage was accepted. Problems in the family were noticed earlier on, but unattended to because of socioeconomic pressures. The identified patient was a boy.

The differences in treatment varied somewhat according to each context and in accordance with my experience. The length and intensity of treatment also varied. Whereas both families visited our Centre over a period of approximately two years, Family A was seen for the first year on a weekly basis, receiving a combination of individual sessions for Melissa, followed by family sessions. Only in the second year were the parents seen alone on a monthly basis. Family B received more intense work by the team, although there were fewer contacts. Seen on a monthly basis, Family B received three family assessment sessions, then four individual sessions for the mother alone, followed by two sessions for the couple alone and the final two sessions for the whole family.

Despite the many differences between the families, the commonalities may point to some wider generalizations. In both cases, the children were unable to grasp the death of their parent, yet they were subjected to the same rules of conduct as adults. Paradoxically, their development was arrested at their level of maturity at their parents' death. Both families lost a parent of the same gender as the surviving children. The implications for gender disturbance in adolescence were indeed among the problems that were of concern upon admission. Academic underachievement is not uncommon in depressed, and in these cases grieving, children. "Death is not easily tolerable, for it can breed shame" (6, p.19). An adolescent who lost a father stated: "A child might lie about her parents being alive. I used to lie all the time. ... I felt ashamed and embarrassed because I was different from everyone else. If I said he was dead, they would all feel sorry for me. I couldn't stand that and would rather lie" (6, p.19). Similarly for stealing, clowning, and, as a last resort, avoidance and denial through use of drugs. Perhaps one other commonality warrants our attention: namely, the period of their lives in which problems became pronounced. Adolescence is a period of beginning adulthood. Hand in hand with identity formation comes the creation of new relationships. Much has already been written about unresolved childhood problems revisiting the adolescent upon facing new beginnings (18).

We could continue to analyze the psychodynamic factors that contributed to these children's problems, but we would then be subject to the same criticism we earlier applied to individual therapists of similar cases. That is, the individualistic approach in these instances serves to isolate the individual from his main source of support (or confusion), the family system. Such isolation or centering, in the Piagetian sense, exaggerates and distorts reality. On the other hand, decentering, which is exemplified by viewing the individual's problems within the family context, brings to focus a more realistic and relational approach (34).

From this perspective, adolescence can be viewed as a trying time for the family system. Roles are subjected to the test of change, as new functions are invoked and the family structure is shaken up to prepare for branching off. Perhaps it is not by accident, therefore, that the point at which these families mobilized themselves in search of treatment came when the parents also experienced problems in beginning new relationships, built upon unresolved pasts. Was the request for help and the cooperation in treatment provoked by the children's problems or by the parents' problems? The answer to this question lies in our present understanding of systems. The family functions as one synchronized whole. Ackerman, among the forefathers of family therapy, stated: "Conflict between the minds of family members and conflict within the mind of any one member stand in reciprocal relation to one another" (1, p.75). From this viewpoint, it is clear that in both cases the surviving parents' unresolved conflict about their dead spouses was expressed through denial of mourning and was reciprocated by the children's refusal to deny. On the other hand, the children's behavior functioned to preserve the unresolved mourning. Their conflict about beginning new lives for themselves thus paralelled that of the couples and perhaps served as a starting point for the couples' work toward resolving this conflict in their marriage. It is this resolution that helped free the couples from marital knots and facilitated the actualization of their parental roles.

Do all families have to go through similar mourning processes? In our particular examples, both families lost a parent at the "wrong time" in their life cycles. According to Hertz, "Those deaths or serious illnesses in which an individual is in the prime of life are the most disruptive to the family" (16, p.225). At this early phase of the family life, a mother or a father has the greatest responsibilities for the family. Their death therefore leaves a structural gap that can be difficult, perhaps impossible, to fill and may indeed interfere with accomplishing family life cycle tasks. In an attempt to compensate for this gap, both families independently added a superfluous role to their systems, that of the ghost. This role's primary function was to disqualify the new marital partner's role, rendering him or her impotent in the face of

current life tasks. For the children, also, it was a constant reminder of the need to fill the gap�because a ghost is not a real parent.

To some extent, one sees these dynamics perpetuated in most second marriages, when a new marital partner is brought in only as a substitute for the ex-partner but is also seen as qualified to provide his or her own contributions to the system. This game of partner-substitution, however, has some retroactive functions as well. It disqualifies and qualifies the ex-partner's role simultaneously. When all is added up, we find ourselves with a family system that works toward minimal change over a maximum amount of time. The struggle to preserve sameness at the expense of innovations within times of change is perhaps comparable to a ship's crew that continues to practice sailing out of the water.

Despite the various contextual differences in the lives of these families, they both resisted�at different points in the process of treatment�the therapist's touching the wound (1). They argued that mourning was not called for at such a late date or for "such a mother who wasn't really mothering" (Family A), or "after so much suffering"(Family B), etc. They would rather have us help them get on with current tasks, than unravel a traumatic past that left some lacunae in their life experience. At most, they were prepared to have us treat the identified patient alone. They were especially concerned not to disturb the newly acquired marital relationship. The turning point in the treatment of both families occurred when the parents realized the deadlock, so to speak, in their marital relations. The harder they tried to redefine a new beginning for the family, the more the system sank into entropy. Stated another way, new beginnings were confused with past endings, and death was confused with living.

There is indeed a fine line between supporting new initiatives in clients' lives and helping resolve painful problems. Although this principle applies to all forms of therapy, in family therapy two essential variables must be considered. One is the length of time between sessions. As the Milan team observed, interventions that affect a change in one member of the family require a certain time span before change reactions of other members become evident. "Case by case, session by session, it is the task of the team to decide upon the length of the interval, which may vary anywhere from two weeks to several months" (38, p.15). In these two cases, the average interval was about one month, although at different points in the process the intervals varied greatly, from three months to one week. The rationale for these decisions rested on monitoring both the innovative and the conservative forces of the systems. It was assumed that these family systems had their own mobilizing forces enabling them to institute marked changes in their lives. Similarly for the conservative forces. My role was to coordinate my input into each system with its own output.

The second variable relates to the first�children best express the family system's tendencies for change and growth. Leaving the children out of the treatment sessions, therefore, perhaps contributed most to the parents' ability to deal with their own mourning of past marriages. On the other hand, focusing on the children's problems during these marital sessions served to encourage innovation and growth. These parents were capable of helping their children by themselves. Hence the interplay between probing and support.

Summary

In Hertz's words:

Societal, familial, and intrapsychic processes all operate to promote the isolation of dying. Our society, in keeping

with its massive denial of death, has created 'death specialists' for dealing with all aspects of the dying. ... With all of

these individuals handling death, the family has gotten increasingly distant from the dying person. [16, p.223]

This paper critically reviewed the individualistic approach to mourning and death, contrasting this approach with systemic presentations of family problems and treatment. The two cases that were presented portrayed the interrelationships between reactions to death and beginning a new life within a family constellation. Individuals' resolve to avoid grief and deny death had negative implications for the whole family and arrested its growth. Based on these assumptions, family therapy was the treatment of choice and proved effective in both cases.

Given that these results were of an exploratory nature, perhaps future work with similar family problems could be more carefully monitored. Certainly, further research in this area would serve to refocus the mourning process back on to the family and perhaps on to the wider sociocultural support systems.

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REFERENCES

Ackerman, N. W., Treating the Troubled Family, New York, Basic Books, 1966.
Anthony, S., The Discovery of Death in Childhood and After, London, Penguin Education, 1973.
Ball, J. F., "Widows' Grief: The Impact of Age and Mode of Death," Omega, 7, 307-333, 1977.
Berman, D. B., "The Facilitation of Mourning: A Preventive Mental Health Approach," Ph.D. Dissertation, University of Massachusetts, 1978.
Bernstein, J. E., "Helping Young Children to Cope With Acute Grief: A Bibliotherapy Approach" in V. R. Fine,
A. H. Kutscher, D. Peretz, R. C. Slater, R. DeBellis, R. J. Volk, and D. J. Cherico,(eds.). Acute Grief and Funeral, Springfield, Ill.: Charles C. Thomas, 1976.
Bertman, S. L., "Children's and Others' Thoughts and Expressions About Death" in H. Wass and C. A. Corr (eds.) Helping Children Cope With Death: Guidelines and Resources, New York, Hemisphere Publishing Corporation, 1982.
Birtchnell, J., "Some Psychiatric Sequelae Of Childhood Bereavement," Brit. J. Psychiat, 116, 346-347, 1970.
Bowen, M., "A Family Concept of Schizophrenia" in D. D. Jackson, (ed.), The Etiology of Schizophrenia, New York, Basic Books, 1960.
Caplan, G., Principles of Preventive Psychiatry, New York, Basic Books, 1964.
Fleck, S., "An Approach to Family Pathology," in G. D. Erickson and T. P. Hogan (eds.), Family therapy: An Introduction To Theory and Technique, Monterey, Calif., Brooks-Cole, 1972.
Freeman, R. D., "Review Of Medicine And Special Education. The Crisis Of Diagnosis: Need For Intervention,"
J. Spec. Ed., 5, 389-414, 1971.
Freud, S., "Premonitory Dreams Fulfilled," in Standard Edition, vol. 5: London, Hogarth Press, 1957.
Fulton, R. and Gottesman, D. J., "Anticipatory Grief: A Psychosocial Concept Reconsidered," Brit J. Psychiat, 137, 45-54, 1980.
Furman, E., A Child's Parent Dies: Studies in Childhood Bereavement, New Haven, Conn., Yale University Press, 1974.

Glick, I. O., Weiss, R. S. and Parkes, C. M., The First Year of Bereavement, New York, John Wiley, 1974.
Herz, F., "The Impact of Death and Serious Illness on the Family Life Cycle,"in E. A. Carter and M. McGoldrick, (eds.) The Family Life Cycle: A Framework For Family Therapy, New York, Gardner, 1980.
Kane, B., "Children's Concepts of Death," J. Genet. Psychol., 134, 141-153, 1979.
Laufer, M., "Object Loss And Mourning During Adolescence," in Psychoanal Study of the Child. vol. 21, 1966.
Laufer, M., "The Analysis of a Child of Survivor" in E. J. Anthony and C. Koupernik (eds.), The Child in His Family, vol. 2, The Impact of Disease and Death, New York, John Wiley, 1973.
Lebovichi, S., "Observations on Children Who Have Witnessed the Violent Death of One of Their Parents: A Contribution to the Study of Traumatization," Int. Rev. Psychoanal, 1, 117-123, 1974.
Levin, S., "Panel Report: Depression And Object Los," J. Am. Psychoanal. Assn., 14, 142-153, 1966.
Leviton, D., "The Need For Education On Death and Suicide," J. School Health, 39, 370-374, 1969.
Lifshitz, M., "Long-Range Effect of Father's Loss: The Cognitive Complexity of Bereaved Children and Their School Adjustment," Brit. J. Med. Psychol., 49, 189-197, 1976.
Liebermann, E. J., "Preventive Psychiatry and Family Planning," J. Marr. Fam., 26, 471, 1964.
Lindemann, E., "The Symptomatology And Management Of Acute Grief," Am. J. Psychiat, 101, 141-148, 1944.
Lonetto, R., Children's Conception of Death, New York, Springer, 1980.
MacGregor, R., "Multiple Impact Psychotherapy With Families," in G. D. Erickson, and T. P. Hogan, (eds.) Family therapy: An Introduction to Theory and Technique, Monterey, Calif., Brooks-Cole, 1972.
Minuchin, S. and Fishman, H. C., Family Therapy Techniques, Cambridge, Mass., Harvard University Press, 1981.
Mitchell, M. E., The Child's Attitude to Death, New York, Schocken Books, 1967.
Nagy, M., "The Child's Theories Concerning Death," J. Genet. Psychol., 73, 3-27, 1948.
Parkes, C. M., "Effect Of Bereavement on Physical and Mental Health�A Study of the Medical Records of Widows, Brit. Med. J., II, 274-279, 1964.
Parsons, T., The Social System, Glencoe, Ill., The Free Press, 1951.
Paul, N., "The Use of Empathy in the Resolution of Grief" Perspectives in Biology and Med. 11; No. 1, Autumn 1967.
Piaget, J. and Inhelder, B., The Psychology of the Child, New York, Basic Books, 1969.
Pollock, G. H., "On Mourning and Anniversaries: The Relationship of Culturally Constituted Defensive Systems to Intrapsychic Adaptive Processes," Israel Annals Psychiat. Related Disciplines, 10, 9-40, 1972.
Rosenblatt, P. C., Walsh, R. P. and Jackson, D. A. (Eds.), Grief and Mourning in Cross-Cultural Perspective, Human Relations Area Files Press, 1976.
Safier, G., "A Study in Relationships Between Life and Death Concept in Children." J. Genet. Psychol., 105, 283-294, 1964.
Selvini-Palazzoli, M., Cecchin, G., Prata, G. and Boscolo, L., Paradox and Counterparadox, New York, Jason Aronson, 1978.
Vachon, M. L. S., Freedman, K., Formo, A., Rogers, J., Lyall, W. A. L. and Freeman, S. J. J., "The Final Illness in Cancer: The Widow's Perspective." Can. Med. Assn. J., 117, 1151-1154, 1977.
[1]Personal conversations and study at the Centro per lo Studio della Famiglia, Milan, Italy, 1981.

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