

Family Reaction to Death

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Direct thinking about death, or indirect thinking about staying alive and avoiding death, occupies more of man's time than any other subject. Man is an instinctual animal with the same instinctual awareness of death as the lower forms of life. He follows the same predictable instinctual life pattern of all living things. He is born, he grows to maturity, he reproduces, his life force runs out, and he dies. In addition, he is a thinking animal with a brain that enables him to reason, reflect, and think abstractly. With his intellect he has devised philosophies and beliefs about the meaning of life and death that tend to deny his place in nature's plan. Each individual has to define his own place in the total scheme and accept the fact that he will die and be replaced by succeeding generations. His difficulty in finding a life plan for himself is complicated by the fact that his life is intimately interwoven with the lives about him. This presentation is directed to death as a part of the total family in which he lives.

There are no simple ways to describe man as part of the relationship around him. In another chapter in this volume, I have presented my own way of conceiving of the human as an individual and, also, as part of the emotional-social amalgam in which he lives. According to my theory, a high percentage of human relationship behavior is directed more by automatic instinctual emotional forces than by intellect. Much intellectual activity goes to explain away and justify behavior being directed by the instinctual-emotional-feeling complex. Death is a biological event that terminates a life. No life event can stir more emotionally directed thinking in the individual and more emotional reactivity in those about him. I have chosen the concept of "open" and "closed" relationship systems as an effective way to describe death as a family phenomenon.

An "open" relationship system is one in which an individual is free to communicate a high percentage of inner thoughts, feelings, and fantasies to another who can reciprocate. No one ever has a completely open relationship with another, but it is a healthy state when a person can have one relationship in which a reasonable degree of openness is possible. A fair

percentage of children have a reasonable version of this with a parent. The most open relationship that most people have in their adult lives is in a courtship. After marriage, in the emotional interdependence of living together, each spouse becomes sensitive to subjects that upset the other. They instinctively avoid the sensitive subjects and the relationship shifts toward a more "closed" system. The closed communication system is an automatic emotional reflex to protect self from the anxiety in the other person, though most people say they avoid the taboo subjects to keep from upsetting the other person. If people could follow intellectual knowledge instead of the automatic reflex, and they could gain some control over their own reactivity to anxiety in the other, they would be able to talk about taboo subjects in spite of the anxiety, and the relationship would move toward a more healthy openness. But people are human, the emotional reactivity operates like a reflex, and, by the time the average person recognizes the problem, it can be impossible for two spouses to reverse the process themselves. This is the point at which a trained professional can function as a third person to work the magic of family therapy toward opening a closed relationship.

Chief among all taboo subjects is death. A high percentage of people die alone, locked into their own thoughts which they cannot communicate to others. There are at least two processes in operation. One is the intrapsychic process in self which always involves some denial of death. The other is the closed relationship system. People cannot communicate the thoughts they do have, lest they upset the family or others. There are usually at least three closed systems operating around the terminally ill person. One operates within the patient. From experience, every terminally ill patient has some awareness of impending death and a high percentage have an extensive amount of private knowledge they do not communicate to anyone. Another closed system is the family. The family gets its basic information from the physician, which is supplemented by bits of information from other sources and is then amplified, distorted, and re-interpreted in conversations at home. The family has its own carefully planned and edited medical communicate for the patient. It is based on the family interpretation of the reports and modified to avoid the patient's reactivity to anxiety. Other versions of the communicate are whispered within the hearing of the patient when the family thinks the patient is sleeping or unconscious. Patients are often alert to whispered communications. The physician and the medical staff have another closed system of communication, supposedly based on medical facts, which is influenced by emotional reactivity to the family and within the staff. Physicians attempt to do factual reports to the family which are distorted by the medical emotionality and the effort to put the correct emphasis on the "bad news" or "good news." The more reactive the physician, the more likely he is to put in medical jargon the family does not hear

or to become too simplistic in his efforts to communicate in lay language. The more anxious the physician, the more likely he is to do too much speechmaking and too little listening, and to end up with a vague and distorted message and little awareness of the family misperception of his message. The more anxious the physician, the more the family asks for specific details the physician cannot answer. Physicians commonly reply to specific questions with overgeneralizations that miss the point. The physician has another level of communication to the patient. Even the physician who agrees with the principle of telling the patient "facts" can communicate them with so much anxiety that the patient is responding to the physician instead of the content of what is being said. Problems occur when the closed communication system of medicine meets the age-old closed system between the patient and the family, and anxiety is heightened by the threat of terminal illness.

My clinical experience with death goes back some 30 years to detailed discussions about death with suicidal patients. They were eager to talk to an unbiased listener who did not have to correct their way of thinking. Then I discovered that all seriously ill people, and even those who are not sick, are grateful for an opportunity to talk about death. Over the years I have tried to do such discussions with seriously ill people in my practice, with friends and people I have known socially, and with members of my extended families. I have never seen a terminally ill person who was not strengthened by such a talk. This contradicts former beliefs about the ego being too fragile for this in certain situations. I have even done this with a spectrum of comatose patients. Terminally ill people often permit themselves to slip into coma. A fair percentage can pull themselves out of the coma for important communications. I have had such people come out long enough to talk and express their thanks for the help and immediately slip back. Until the mid-1960's, a majority of physicians were opposed to telling patients they had a terminal illness. In the past decade the prevailing medical dictum about this has changed a great deal, but medical practice has not kept pace with the changed attitude. The poor communications between the physician and the patient, and between the physician and the family, and between the family and the patient are still very much as they were before. The basic problem is an emotional one, and a change in rules does not automatically change the emotional reactivity. The physician can believe he gave factual information to the patient, but in the emotion of the moment, the abruptness and vagueness in the communication, and the emotional process in the patient, the patient failed to "hear." The patient and the family can pretend they have dealt clearly with each other without either being heard through the emotionality. In my family therapy practice within a medical center, I am frequently in contact with both the patient and the family, and to a lesser extent with the physicians. The closed system between the patient and the

family is great enough, at best. I believe the poor communication between the physician and the family and between the physician and the patient is the greatest problem. There have been repeated situations in which the physicians thought they were communicating clearly, but the family either misperceived or distorted the messages, and the family thinking would be working itself toward malpractice anger at the physician. In all of these, the surgical and medical procedures were adequate, and the family was reacting to terse, brief speeches by the physician who thought he was communicating adequately. In these, it is fairly easy to do simple interpretations of the physician's statements and avert the malpractice thinking I believe the trend toward telling patients about incurable illness is one of the healthy changes in medicine, but closed systems do not become open when the surgeon hurriedly blurts out tense speeches about the situation. Experience indicates that physicians and surgeons have either to learn the fundamentals of closed system emotionality in the physician-family-patient triangle, or they might avail themselves of professional expertise in family therapy if they lack the time and motivation to master this for themselves. A clinical example of closed system emotionality will be presented later.

FAMILY EMOTIONAL EQUILIBRIUM AND THE EMOTIONAL SHOCK WAVE

This section will deal with an order of events within the family that is not directly related to open and closed system communications. Death, or threatened death, is only one of many events that can disturb a family. A family unit is in functional equilibrium when it is calm and each member is functioning at reasonable efficiency for that period. The equilibrium of the unit is disturbed by either the addition of a new member or the loss of a member. The intensity of the emotional reaction is governed by the functioning level of emotional integration in the family at the time, or by the functional importance of the one who is added to the family or lost to the family. For instance, the birth of a child can disturb the emotional balance until family members can realign themselves around the child. A grandparent who comes for a visit may shift family emotional forces briefly, but a grandparent who comes to live in a home can change the family emotional balance for a long period. Losses that can disturb the family equilibrium are physical losses, such as a child who goes away to college or an adult child who marries and leaves the home. There are functional losses, such as a key family member who becomes incapacitated with a long-term illness or injury which prevents his doing the work on which the family depends. There are emotional losses, such as the absence of a light-

hearted person who can lighten the mood in a family. A group that changes from light-hearted laughter to seriousness becomes a different kind of organism. The length of time required for the family to establish a new emotional equilibrium depends on the emotional integration in the family and the intensity of the disturbance. A well integrated family may show more overt reactivity at the moment of change but adapt to it rather quickly. A less integrated family may show little reaction at the time and respond later with symptoms of physical illness, emotional illness, or social misbehavior. An attempt to get the family to express feelings at the moment of change does not necessarily increase the level of emotional integration.

The "Emotional Shock Wave" is a network of underground "after shocks" of serious life events that can occur anywhere in the extended family system in the months or years following serious emotional events in a family. It occurs most often after the death or the threatened death of a significant family member, but it can occur following losses of other types. It is not directly related to the usual grief or mourning reactions of people close to the one who died. It operates on an underground network of emotional dependence of family members on each other. The emotional dependence is denied, the serious life events appear to be unrelated, the family attempts to camouflage any connectedness between the events, and there is a vigorous emotional denial reaction, when anyone attempts to relate the events to each other. It occurs most often in families with a significant degree of denied emotional "fusion" in which the families have been able to maintain a fair degree of asymptomatic emotional balance in the family system. The basic family process has been described in another chapter in this volume.

The "Emotional Shock Wave" was first encountered in the author's family research in the late 1950's. It has been mentioned in papers and lectures, but it has not been adequately described in the literature. It was first noticed in the course of multigenerational family research with the discovery that a series of major life events occurred in multiple, separate members of the extended family in the time interval after the serious illness and death of a significant family member. At first, this appeared to be coincidence. Then it was discovered that some version of this phenomenon appeared in a sufficiently high percentage of all families, and a check for the "shock wave" is done routinely in all family histories. The symptoms in a shock wave can be any human problem. Symptoms can include the entire spectrum of physical illness from an increased incidence of colds and respiratory infections to the first appearance of chronic conditions, such as diabetes or allergies to acute medical and surgical illnesses. It is as if the shock wave is the stimulus that can trigger the physical process into activity. The symptoms can also include the full range of emotional symptoms from mild depression, to phobias, to psychotic episodes. The social dysfunctions

can include drinking, failures in school or business, abortions and illegitimate births, an increase in accidents, and the full range of behavior disorders. Knowledge of the presence of the shock wave provides the physician or therapist with vital knowledge in treatment. Without such knowledge, the sequence of events is treated as separate, unrelated events.

Some examples of the shock wave will illustrate the process. It occurs most often after the death of a significant family member, but it can be almost as severe after a threatened death. An example was a grandmother in her early 60's who had a radical mastectomy for cancer. Within the following two years, there was a chain of serious reactions in her children and their families. One son began drinking for the first time in his life, the wife of another son had a serious depression, a daughter's husband failed in business, and another daughter's children became involved in automobile accidents and delinquency. Some symptoms were continuing five years later when the grandmother's cancer was pronounced cured. A more common example of the shock wave follows the death of an important grandparent, with symptoms appearing in a spectrum of children and grandchildren. The grandchild is often one who had little direct emotional attachment to the grandparents. An example might be the death of a grandmother, a daughter who appeared to have no more than the usual grief reaction to the death but who reacted in some deep way, and who transmitted her disturbance to a son who had never been close to the grandmother but who reacted to the mother with delinquency behavior. The family so camouflages the connectedness of these events that family members will further camouflage the sequence of events if they become aware the therapist is seeking some connectedness. Families are extremely reactive to any effort to approach the denial directly. There was a son in his mid-30's who made a plane trip to see his mother who had had a stroke and who was aphasic. Before that time, his wife and children were leading an orderly life, and his business was going well. His effort to communicate with his mother, who could not speak, was a trying experience. Enroute home on the plane, he met a young woman with whom he began the first extramarital affair in his life. During the subsequent two years, he began living a double life, his business was failing, and his children began doing poorly in school. He made a good start in family therapy which continued for six sessions when I made a premature connection between his mother's stroke and the affair. He cancelled the subsequent appointment and never returned. The nature of the human phenomenon is such that it reacts vigorously to any such implications of the dependence of one life on another. Other families are less reactive and they can be more interested in the phenomenon than reactive to it. I have seen only one family who had made an automatic connection between such events before seeking therapy. This was a father who said, "My family was calm and healthy until two years ago when my daughter was married. Since

then, it has been one trouble after another, and the doctor bills have become exorbitant. My wife had a gall bladder operation. After that, she found something wrong with each house where we lived. We have broken three leases and moved four times. Then she developed a back problem and had a spinal fusion. My son had been a good student before my daughter married. Last year, his school work went down and this year he dropped out of college. In the midst of this, I had a heart attack." I would see this as a family with tenuously balanced emotional equilibrium in which the mother's functioning was dependent on her relationship with the daughter. Most of the subsequent dysfunction was in the mother, but the son and father were sufficiently dependent on the mother that they too developed symptoms. The incidence of the emotional shock wave is sufficiently prevalent that the Georgetown Family Section does a routine historical check for it in every family history.

Knowledge of the emotional shock wave is important in dealing with families on death issues. Not all deaths have the same importance to a family. There are some in which there is a fair chance the death will be followed by a shock wave. Other deaths are more neutral and are usually followed by no more than the usual grief and mourning reactions. Other deaths are a relief to the family and are usually followed by a period of better functioning. If the therapist can know ahead of time about the possibility of an emotional shock wave, he can take some steps toward its prevention. Among the deaths most likely to be followed by a serious and prolonged shock wave are the deaths of either parent when the family is young. This not only disturbs the emotional equilibrium, but it removes the function of the breadwinner or the mother at a time when these functions are most important. The death of an important child can shake the family equilibrium for years. The death of the "head of the clan" is another that can be followed by a long-term underground disturbance. It can be a grandfather who may have been partially disabled but who continued some kind of decision making function in family affairs. The grandmothers in these families usually lived in the shadow of their husbands, and their deaths were less important. The family reaction can be intense following the death of a grandmother who was a central figure in the emotional life and stability of the family. The "head of the clan" can also be the most important sibling in the present generation. There is another group of family members whose deaths may result in no more than the usual period of grief and mourning. They may have been well liked, but they played peripheral roles in family affairs. They are the neutral ones who were neither "famous nor infamous." Their deaths are not likely to influence future family functioning. Finally, there are the family members whose deaths are a relief to the family. This includes the people whose functioning was never critical to the family, and who may have been a burden in their final illness. Their deaths may be

followed by a brief period of grief and mourning, which is then followed by improved family functioning. A shock wave rarely follows the death of a dysfunctional family member unless that dysfunction played a critical role in maintaining family emotional equilibrium. Suicides are commonly followed by prolonged grief and mourning reactions, but the shock wave is usually minor unless the suicide was an abdication of an essential functional role.

THERAPY AT THE TIME OF DEATH

Knowledge of the total family configuration, the functioning position of the dying person in the family, and the overall level of life adaptation are important for anyone who attempts to help a family before, during, or after a death. To attempt to treat all deaths as the same can miss the mark. Some well functioning families are able to adapt to approaching death before it occurs. To assume that such families need help can be an inept intrusion. Physicians and hospitals have left much of the problems about death to chaplains and ministers with the expectation they know what to do. There are exceptional clergymen who intuitively know what to do. However, many young chaplains or clergymen tend to treat all death as the same. They operate with their theology, a theory about death that does not go beyond the familiar concepts of grief and mourning, and they tend to aim their help at the overt expression of grief. This may provide superficial help to a majority of people, but it misses the deeper process. The popular notion that expression of grief through crying may be helpful to most complicates the situation for others. It is important for the physician or therapist to know the situation, to have his own emotional life under reasonable control without the use of too much denial, or other extreme mechanisms, and to respect the denial that operates in the family. In my work with families, I carefully use direct words, such as death, die, and bury, and I carefully avoid the use of less direct words, such as passed on, deceased, and expired. A direct word signals to the other that I am comfortable with the subject, and it enables others to also be comfortable. A tangential word may appear to soften the fact of death; but it invites the family to respond with tangential words, and the conversation soon reaches the point that one wonders if we are talking about death at all. The use of direct words helps to open a closed emotional system. I believe it provides a different dimension in helping the family to be comfortable within themselves.

The following is a clinical example that illustrates an effort to open the communication with a terminally ill patient, her family, and the medical staff. As a visiting professor in another medical center, I was scheduled to

do a demonstration interview with the parents of an emotionally disturbed daughter. Enroute to the interview room, I learned the mother had a terminal cancer, that the surgeon had told the father, and the father had told the family therapist, but that the mother did not know about it. In my own practice, it would have been automatic to discuss this issue with the family, but I was reluctant to take this course when follow-up interviews would not be possible. A large group of professional people and trainees observed the interview. I elected to avoid the critical issue. The beginning of the interview was awkward, difficult, and sticky. I decided the cancer issue had to be discussed. About ten minutes out, I asked the mother why she thought her surgeon, her family, and the others had not told her about her cancer. Without the slightest hesitation, she said she thought they were afraid to tell her. She calmly said, "I know I have cancer. I have known it for sometime. Before that, I was afraid of it, but they told me it was not cancer. I believed them for a time, thinking it was my imagination. Now I know it is cancer. When I ask them and they say "No," what does it mean? It either means they are liars or I am crazy, and I know I am not crazy." Then she went into detail about her feelings, with some moderate tears, but with full control of herself. She said that she was not afraid to die for herself, but she would like to live long enough to see the daughter have a life for herself. She hated the responsibility of leaving the daughter the responsibility of the father. She spoke with deep feeling but few tears. She and I were the calmest people in the room. Her therapist wiped away tears. The father reacted by joking and kidding about the mother's vivid imagination. To prevent his reaction from silencing her, I made a few comments to suggest he not interfere with his wife's serious thoughts. She was able to continue, "This is the loneliest life in the world. Here I am, knowing I am going to die, and not knowing how much time I have left. I can't talk to anyone. When I talk to my surgeon, he says it is not a cancer. When I try to talk to my husband, he makes jokes about it. I come here to talk about my daughter and not about myself. I am cut off from everyone. When I get up in the morning, I feel terrible. I look at my eyes in the mirror to see if they are jaundiced and the cancer has spread to my liver. I try to act cheerful until my husband goes to work, because I don't want to upset him. Then I am alone all day with my thoughts, just crying and thinking. Before my husband returns from work, I try to pull myself together for his sake. I wish I could die soon and not have to pretend any longer." Then she went into some background thoughts about death. As a little girl she felt hurt when people walked on graves. She had always wished she could be buried above ground in a mausoleum, so people would not walk on her grave. "But," she said, "we are poor people. We can't afford a mausoleum. When I die, I will be buried in a grave just like everyone else." The technical problem in this single interview was to permit the mother to talk, to keep the father's

anxiety from silencing her, and to hope the regular therapist could continue the process later. It is impossible to do much toward opening an emotionally closed relationship of this intensity in a single session, although the father said he would try to listen and understand. The patient was relieved to be partially out of the closed system in which she had lived. The therapist said she had known about the cancer but had been waiting for the mother to bring it up. This is a common posture for mental health professionals. The therapist's own emotionality had prevented the wife from talking. At the end of the interview, the mother said, smiling through her tears, "We have sure spent an hour walking around on my grave, haven't we?" As I said goodbye to them in the hall, the mother said, "When you go home tonight, thank Washington for sending you here today." The less expressive father said, "We are both grateful." There were a few minutes with the audience who had observed the interview. Part of the group had been moved to tears, most were silent and serious, and a few were critical. The criticism was expressed by a young physician who spoke of hurting the wife and having taken away her hope. I was pleased at having decided to take up this issue in this single demonstration interview. Enroute home, my thoughts went to the differences in audience response and the problems of training young professional people to contain their own emotionality sufficiently to become more objective about death. I guessed it would be easier to train those who cried than those who intellectualized their feelings. This is an example of a good result in a single session. It illustrates the intensity of a closed relationship system between the patient, the family, and the medical staff.

THE FUNCTION OF FUNERALS

Some 25 years ago, I had a clinical experience that illustrates the central point of the next section of this chapter. A young woman began psychoanalysis with, "Let me bury my mother before we go to other things." Her mother had been dead six years. She cried for weeks. At that time, I was practicing within the framework of transference and intrapsychic dynamics. The patient's statement was used later as a way of describing systems theory about the unresolved emotional attachments between people that remain viable for life, that attach to significant future relationships, and that continue to direct the course of a life. There is a way to utilize the funeral to more completely "bury the dead at the time of death." Few human events provide as much emotional impact as serious illness and death in resolving unresolved emotional attachments.

The funeral ritual has existed in some form since man became a civilized being. I believe it serves a common function of bringing survivors into

intimate contact with the dead and with important friends, and it helps survivors and friends to terminate their relationship with the dead and to move forward with life. I think the best function of a funeral is served when it brings relatives and friends into the best possible functional contact with the harsh fact of death and with each other at this time of high emotionality. I believe funerals were probably more effective when people died at home with the family present, and when family and friends made the coffin and did the burial themselves. Society no longer permits this, but there are ways to bring about a reasonable level of personal contact with the dead body and the survivors.

There are numerous present-day funeral customs that function to deny death and to perpetuate the unresolved emotional attachments between the dead and the living. It is most intense in people who are anxious about death and who use the present form and content of funerals to avoid the anxiety. There are those who refuse to look at a dead body because, "I want to remember them as I knew them." There is the anxious segment of society that refers to funerals as pagan rituals. Funeral custom makes it possible for the body to be disposed of from the hospital without the family ever having personal contact with it. Children are commonly excluded from funerals to avoid upsetting them. This can result in a lifetime of unrealistic and distorted fantasies and images that may never be corrected. The private funeral is another custom that avoids the emotionality of death. It is motivated by family anxiety to avoid contact with emotionality in others. It prevents the friendship system an opportunity to terminate their relationship with the dead, and it deprives the family of the supportive relationships from friends.

I believe that professional support to a family at the time of death can help the family members toward a more helpful funeral than would be possible if they listened to advice from anxious relatives and friends. In 20 years of family practice, I have had contact with several thousand families, and I have been in the background "coaching" families through hundreds of deaths and funerals. I urge family members to visit dying family members whenever possible and to find some way to include children if the situation permits. I have never seen a child hurt by exposure to death. They are "hurt" only by the anxiety of survivors. I encourage involvement of the largest possible group of extended family members, an open casket, and the most personal contact that is possible between the dead and the, living, prompt obituary notices, and the notification of relatives and friends, a public funeral with the body present, and the most personal funeral service that is possible. Some funeral services are highly ritualized but it is possible to personalize even the most ritualized service. The goal is to bring the entire family system into the closest possible contact with death in the presence of the total friendship system and to lend a helping hand to the

anxious people who would rather run than face a funeral.

The following is an example of coaching friends from the background. It involved neighbors rather than people in my professional practice. The young parents in their early thirties and their three children ages ten, eight, and five, had come to live with her widowed mother in preparation for the husband's going overseas on a prolonged assignment. On a Sunday one month before his scheduled departure, the young mother died suddenly of a heart attack. The entire community was shocked. That evening, I spent some three hours with the father. He and the wife had been very close. He had dozens of questions about how to handle the present emergency, the funeral, the future of the children, and his own life. He wondered if the children should go to school the next day, what he should tell the teachers, and if he should seek release from his overseas work. In the afternoon, he had tried to tell the children about the mother's death, but he started to cry and the children responded, "Please don't cry, Daddy." He said he simply had to have another mother for the children, but he felt guilty saying this only eight hours after his wife had died. During the visit, I outlined what I would consider to be the ideal course of action for him. I suggested he take as many of the ideas as were consistent with himself, and if they made sense to him, to use them as far as he could go. I suggested that the ability of children to deal with death depends on the adults, and the future would be best served if the death could be presented in terms the children could understand and they could be realistically involved in the funeral. I warned him of adverse emotional reactions of friends and to be prepared for criticism if he decided to involve the children. In the first hours after the death, the children had been responding to his emotionality rather than to the fact of the mother's death. In this kind of a situation, it is common for the children to stop talking and deny the death. I suggested that he get through this block by mentioning the death at frequent intervals during the coming days, and, if he started to cry, to reassure the children that he was all right and not to worry about him. I wanted to keep the channel open for any and all questions they might have. I suggested that the children decide whether or not they wished to go to school the next day. On the issue of involving the children with the dead mother, I suggested that he arrange a time before the funeral to take the children to the funeral home, to remove all other people from the room, and for him and the children to have a private session with their dead mother. I reasoned that this would help the children adapt to the reality of the mother's death, and that it could work if anxious members of the extended family were excluded. On Tuesday evening, I spent an hour in the bedroom, with the father in a chair and the three children in his lap. He could cry, and they could cry, and the children were free to ask questions. He told them about the plan to go to the funeral home the

mie. The father looked to me for an answer. I suggested that would be between the son and his mother. Later, in the living room, I announced to the relatives and friends that the father would take the children to the funeral home the next afternoon, that it was to be private, and that no one else could be present. Privately, I considered it unwise to expose the children to the emotionality in that family. The father's mother said, "Son, that will be too hard on you." The father replied, "Mother, shut up. I can do it." On Wednesday evening, I visited the funeral home. The entire family-friendship system was present. The maternal grandmother, who had been calm through these days, said, "Thank you very much for your help." The father did a detailed account of the children's visit in the afternoon. The children went up to the casket and felt their mother. The five-year-old son said, "If I kissed her, she could not kiss back." All three spent some time inspecting everything, even looking under the casket. The eight-year-old son got under the casket and prayed that his mother could hold him in her arms again in heaven. Some family friends came while the father and children were in the room. The father and children withdrew to the lobby while the friends went into the room. In the lobby, the youngest son found some polished pebbles in a planter. He was the one who found objects to give his mother as "presents." He took a small pebble into the room and placed it in his mother's hand. The other children also got pebbles and put them into their mother's hand. Then they announced, "We can go now, Daddy." The father was much relieved at the outcome of the visit. He said, "A thousand tons were lifted from this family today." The following day I attended the funeral. The children did well. The ten-year-old daughter and eight-year-old son were calm. During the service, the eight-year-old whispered to the father, "Daddy, I sure am going to miss Mommie." The five-year-old clung to the father with some tearfulness.

There was some criticism about the father involving the children in the funeral, but he did well with it and the criticism turned to admiration after the funeral home visit. I was in close contact with the family the following year. The father continued to mention the mother's death. Within a week, the children were talking about the mother in the past tense. The children stayed with their grandmother. There were none of the usual complications usually seen after a death of this kind. The father took an assignment closer home, so he could return if he was needed. The following year, the father remarried and took the children with him and his new wife to another city. It has now been 12 years since the death and the family adjustment has been perfect. I am still in periodic contact with the family, which now includes three grown children from the first marriage and younger children from the second marriage. Some years after the death, the father wrote his version of the experience when the first wife died, entitled, "My God, My Wife Is Dead." He described his initial shock, his efforts to get beyond self-pity, his

resolution to make his own decisions when anxiety was high, and the emotional courage that went into his plan in the critical days before the funeral and burial. This illustrates what I would consider an optimum result from a traumatic death that could have had lifelong sequelae; but this father had more inner strength than any other relative I have seen under stress of this intensity.

SUMMARY

Family systems theory provides a broader perspective of death than is possible with conventional psychiatric theory, which focuses on death as a process within the individual. The first part of this chapter deals with the closed relationship system between the patient, the family, and physicians, and family therapy methods that have been helpful in overcoming some of the anxiety that creates the closed system communication. The second section deals with the "Emotional Shock Wave" that is present to some degree in a significant percentage of families. Knowledge of this, which is the direct result of family research, provides the professional person with a different dimension for understanding emotional interdependence and the long-term complications of death in a family. The final section deals with the emotional impact of funerals and ways the professional person can help surviving relatives to achieve a better level of emotional functioning by calmly facing the anxiety of death.