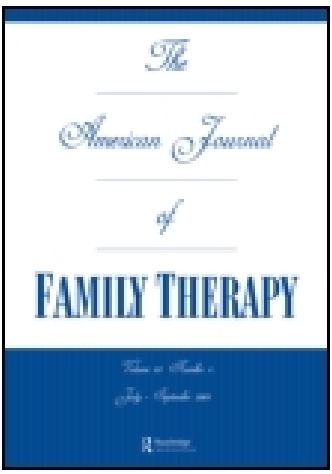

The American Journal of Family Therapy

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/uaft20

Death in the Family: Adapting a Family Systems Framework to the Grief Process

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Published online: 30 Nov 2010.

To cite this article: Joseph McBride & Steven Simms (2001) Death in the Family: Adapting a Family Systems Framework to the Grief Process, The American Journal of Family Therapy, 29:1, 59-73, DOI: 10.1080/01926180126032

To link to this article: http://dx.doi.org/10.1080/01926180126032

The American Journal of Family Therapy, 29:59–73, 2001

0192-6187/01 $12.00 + .00

Death in the Family: Adapting a Family Systems Framework to the Grief Process

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This paper presents a framework for adapting a family systems approach to the grief process. The framework places the bereaved and therapist in the larger context. The therapist builds a relationship around each family member's unique experience with death, and uses the grief timeline to facilitate timely systemic interventions. This perspective helps the therapist navigate pitfalls and remain strategically positioned to address grief sensitively and effectively in psychotherapy.

Laugh and the world laughs with you, weep and you weep alone.
Ella Wheeler Wilcox

This article describes an approach organized as a primer for therapists seeking to build a clinical framework that addresses death and the grief process within a brief family systems model. The framework orients the therapist to attend to three fundamental activities. The first is to develop an awareness of the larger context of death in which families grieve. Second, it emphasizes building relationships with families around their unique experience of death. The third is to facilitate timely systemic interventions. Using the grief timeline to strategically time interventions has not been emphasized in the family therapy literature.

Death is a natural and expected life event. Western civilization has cultivated a context, however, which often veils the grief process and sustains

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barriers for the bereaved (Walsh, 1983). Systematic attention to death as a developmental and family process in psychotherapy (Walsh, 1983; Walsh & McGoldrich, 1991; Shapiro, 1994; Ventura, 1996) is gaining more clinical and research attention (Fristad, Jedel, Weller, & Weller, 1993; Videka-Sherman & Lieberman, 1985). When grief is the presenting "symptom" or a death of a loved one occurs during psychotherapy, therapists-in-training (Munichin & Nichols, 1993, pp. 263–287) and some experienced psychotherapists (Worden, 1991, pp. 133–140) may find themselves grappling uncharacteristically for a foothold in the unfamiliar terrain of death.

The context of death may organize the therapist to avoid the topic and unwittingly direct the process away from death to other less stressful but familiar therapeutic issues. The therapist must attend to the context and timing issues in order to avoid this interpersonal process (Munichin, 1974, p. 106). By failing to recognize this influence on the therapy process from the larger context of denial, the therapist can inadvertently miss the bereavement issues as the essential focus.

DEATH IN CONTEXT

We live in a death denying and death-defying society (DeSpelder & Strickland, 1987). We drive our cars fast, drink and eat to excess at fast food restaurants, smoke, overwork, all with the unspoken idea that death happens to the other person. Death is constantly in our view, through the instant media exposure of tragedies or by the deaths in our families and daily lives. We spend precious little time discussing it with our family and friends. For example, how often is it that the preferred manner of dealing with a bereaved person is to not talk to them about the dead lest we upset that person or ourselves?

It is in this larger context that one must suffer through the bereavement process (Walsh & McGoldrich, 1991). The context often does not provide for awareness of recovery or support. This is a form of institutionalized denial, fostered by a declining influence of religion and its rituals, the lack of education about bereavement on all levels, and a media- induced positive characterization of people who push on despite loss.

THE THERAPIST IN CONTEXT

This framework begins with the focus on the therapist. The first fundamental activity is to tune into the context of death. Every discussion about death and related issues, including therapeutic bereavement encounters, is colored by the denying and defying perspective. The therapist establishes and then sustains a focus on the death experience in context. It is this experience of grief with uncertain and ambivalent support that drives the bereaved to therapy.

A therapist who appreciates the experience of the bereaved and understands his or her own place in this context of denial becomes a more powerful "helper." This means that the therapist is aware of the pressure that the context places on the bereaved to not express their intense feelings. Also, the therapist needs to tune into his or her own understanding of this context and its influence on setting a therapeutic tone that provides a safe environment for the bereaved. Shapiro states this clearly when she says, "Our self awareness when facing the challenging work of grief therapy constitutes the only deterrent against our almost inevitable attempts, both personal and professional, to bring quick resolution to the slow, complex process of healing" (Shapiro, 1994, p. 5).

The therapist must also be sensitive to how lifestyle, family life, ethnic, cultural heritage, and community identity perspectives influence the context of denial (McGoldrich, Almeida, Hines, Garcia-Preto, Rosen, & Lee, 1991). In an attempt to cultivate an appreciation for the many facets of diversity, the therapist must assess these influences. These may include the individual's race, gender, sexual orientation, or national origin and also what the client feels are the important influences on their experience (Lifton, 1968, 1973).

TIMING AS AN INTERVENTION AND THERAPEUTIC RELATIONSHIPS

A focused intervention schema that is sensitive to timing and relationship issues in the bereavement process is crucial. The facilitation of timely systemic interventions requires seeing grief as normal, timing the interventions with the grief process and constant attention to the relationship. A sharp focus on the grief time line (Tames, 1977) helps the therapist effectively time each session and to allow the bereaved opportunities to accomplish the four tasks of grief: accept the reality of the loss, experience the pain, adapt to the new environment, and reinvest emotional energy (Worden, 1991). This framework also helps therapists challenged by a cost-conscious health care reimbursement system to maximize treatment outcomes.

Timing of Sessions

The importance of strategically timing sessions is not emphasized in the bereavement therapy literature. Asking how and when the death occurred is the first key step. The answer indicates which paths families take into the treatment process and helps determine the timing of interventions. Families can typically take three different paths to therapy. The primary path is where the death of a loved one is the reason for the referral. The secondary path is where a client or family is referred to therapy with a presenting behavioral, psychiatric, or family problem, but during treatment the issue of grief surfaces as a central issue. The delayed path is one in which the client or family

TABLE 1. Initiation and frequency of sessions

	Death to Therapy - Months	Number of Sessions
Murder/suicide	4.30	12.52
Sudden death	6.02	8.67
Natural causes	7.58	6.72
Total	6.28	8.71

enters treatment many years after a death. The presenting complaint is linked to unresolved issues surrounding the death. This paper will focus on the primary path.

In cases that follow the primary path, the first step in deciding the timing of sessions for the therapist is to assess the family's pace of grieving within their cultural and ethnic context. Since treatment is by its nature time-limited, it is important to maximize the use of sessions that are available. The therapist does this by matching the intervention with the critical phases of the grief process.

In 106 families referred to the first author's practice with the primary presenting problem of the death of a family member, the average time of entry into treatment from the death was 6.6 months (Table 1). The average number of sessions was eight (Table 1). Looking closer at these families where a family member died of a murder/suicide, entry into treatment was earlier than the other categories at 4.3 months from the time of death. The average number of sessions was 12.5. Sudden death survivors (unexpected death from accident, heart attack, or other medical reasons) were the next group to enter therapy at an average of 6 months and 8.7 sessions. Families in which natural causes (chronic or terminal illness) resulted in the death entered therapy at 7.6 months and averaged 6.7 sessions. The race of the families included 71 Caucasian, 33 African-American, 1 Latino, and 1 Asian-American family (Table 2).

This practice-based pattern points to the relevance of this model, in particular, the importance of the timing of sessions to mirror the grief process relevant to the type of death. As an example, in families where the death was from natural causes, the entry into treatment was at 7.6 months. This is the time when the bereaved are emerging from the shock phase of the bereavement process and starting to experience the emotional rollercoaster of the disorganization phase. The therapeutic process, which begins at this

TABLE 2. Type of death and race

	Caucasian	African-American	Other	Total
Murder/suicide	11	11	1	23
Sudden death	32	8		40
Natural causes	28	14	1	43
Total	71	33	2	106

point, includes attending to the larger framework of entry and timing of the sessions to the grief timeline.

Therapeutic Relationships

It is important for the therapist to create a safe environment for the bereaved to talk about the deceased. Open and factual terminology is essential. This includes assessing the level of anger, blame and responsibility concerning the situation, events, and the person who died. This careful tracking of the events before, during, and after the death provide needed insight. It is helpful to acquire the details of the funeral. This is often overlooked and can provide valuable information for the therapist. It is these events, surrounding the death and the funeral, which can provide the therapist a first look at the level of functioning of a family and an opportunity to create a working relationship. The old Irish expression, "where there is a funeral, there is a fight," lends some folk wisdom to this concept.

At this point, the therapist begins to gain an understanding of how the death has impacted the survivors and to understand how the death has changed the structure of the family. Who disciplines since the father who took most of this responsibility is no longer there? Are the parents capable of caring for each other or their other children after the death of their child? The variations of this are as extensive as the number of families that experience a death. The therapist needs to appreciate that the changes in the context created by the loss will have a powerful impact on the behavior of the survivors and will influence their personal grief processes.

FAMILY SYSTEMS FRAMEWORK

Grief Timeline

The grief timeline is a useful way to describe the process of grief. It offers a picture of the experience for the bereaved. While there are different versions of this concept (Bowlby, 1980; Gilliland & James, 1988; Clayton, 1990), an awareness of following a timeline facilitates the application of this concept in the therapy process. This grief timeline comprises three distinct but overlapping phases called shock, disorganization, and reorganization (see Figure 1; Tames, 1977).

The therapist utilizes the timeline to highlight the bereaved individual's position and important transitions in the grief process to both design and implement interventions. When clients and families present from the primary and delayed paths, the therapist uses the grief timeline to plan the start of therapy. From the secondary path, the therapist uses the grief timeline to address grief within the therapy process.

It is important for the therapist to adapt the timing of the sessions with the place of the bereaved in the grief timeline. Initially, the client may re-

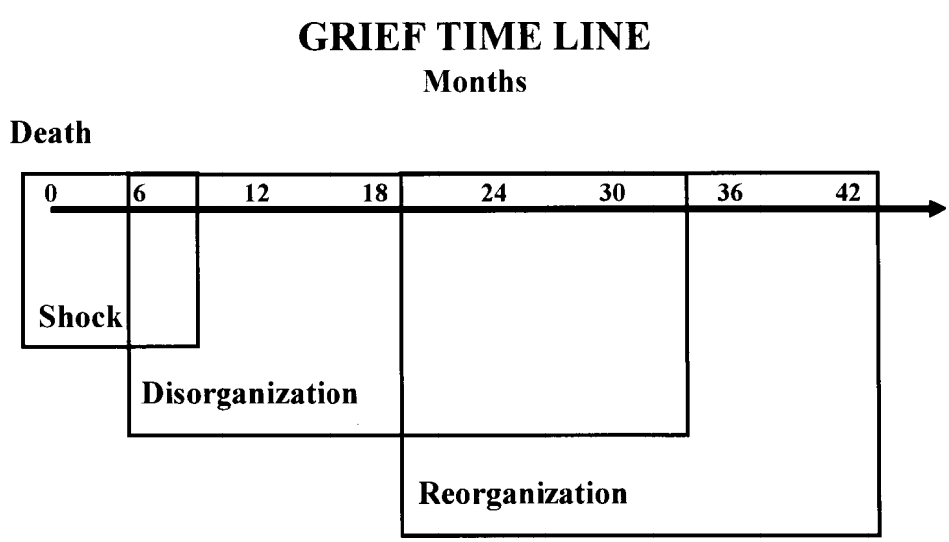

FIGURE 1. Grief timeline.

quire more frequent contact with the therapist. It is essential for the therapist to remain flexible including availability for phone contact and more frequent sessions. This is because the bereaved are feeling overwhelmed, isolated, and at a time when they are usually emerging from the shock phase. Weekly sessions are typical although more contact may be needed. As the client progresses through the disorganization phase, the frequency of sessions is decreased. First, the sessions are decreased to every other week, then monthly as the client progresses, based on his or her ability to cope with the varying intensity of the grief process. It is important to arrange to be with the client through the first year of the process. The pacing of sessions to cover this period allows the therapist to work with the client through the most important and potentially difficult transitions of the process. This includes difficult waves of grief that occur when clients feel that they are finally seeing progress. Anniversaries, birthdays and other significant events in the family life are almost always challenging for the bereaved. The timing of sessions in synchronization with the grief timeline is the therapeutic intervention. Phone contact is maintained throughout the therapeutic process as needed.

Shock Phase

In the shock phase, the bereaved may show a familiar set of indicators of grief. Shock, numbness, and crying are often evident and may persist for weeks to months. Daily activities may be done in mechanistic fashion. Although this aspect of grief may be described as a negative experience, its adaptive function serves to insulate the bereaved from an overwhelming

emotional experience. The immediate response from others is to increase closeness after the death. However, the bereaved often require emotional distance (Tames, 1977). It is ironic that many of our Western traditions find people interested in the bereaved at the time when they are least likely to be able to benefit from the emotional support and personal closeness. The therapist needs to avoid being seduced by the bereaved wanting to push away from the task at hand, since it can be counterproductive to this phase of the grief process. The therapist and bereaved need to acknowledge the expression of the symptoms as part of the grief process.

Disorganization Phase

This phase can last many months to years. It presents the most difficult challenges for both the bereaved (Tames, 1977) and the therapist. It is here that the bereaved experiences the strongest feelings of grief. In contrast to the shock phase, the bereaved now seek an intimate connection with others to talk about the deceased and their feeling that they may be "going crazy." The intimacy of interpersonal relationships allows for the strong ventilation of feelings. It is here that barriers emerge and others distance themselves from the bereaved. The therapist must understand that the overwhelming indicators of grief in this phase can present in a variety of emotional expression such as sadness, anger, anxiety, and guilt (Worden, 1991). This contributes to the difficult and intense nature of this phase of the therapy process. The context of the denial of death becomes more evident. The bereaved are cautioned not to talk about the deceased at a time when it is most important. The therapist needs to be aware that the emotional intensity can increase to seemingly "unmanageable" for the bereaved

The structure and functioning of the family are impacted. Grief affects the ability of family members to perform their roles (Hare-Mustin, 1979). The therapist attends to how death and grief change the day-to-day roles and activities of each family member. As an example, parents may find it difficult to discipline their surviving children. The disrupted hierarchy and discipline may affect the development of the child and the family. The consequences for each family are based in their premorbid level of functioning, the role of the deceased, support system, and the family members' flexibility to adapt to the changes.

Reorganization Phase

In this phase, the bereaved may still have deep feelings toward their loved one, but they are more successful in negotiating the world in the face of their loss. During this phase, the indicators of grief are less evident. Grief reactions are present but the duration and intensity of expression is reduced. When the bereaved establishes a new and balanced relationship with the deceased, they can negotiate reentering the mainstream of life in a meaning-

ful manner. As a result, the bereaved expands their participation in their social network. They start functioning on a level comparable to before the loss.

FOUR TASKS OF MOURNING

Worden offers a task-oriented framework of mourning at the individual and family level (Worden, 1991). The combination of the timeline with the four basic tasks provides a more comprehensive picture of the grief process. This enables the therapist to design therapeutic interventions that are in sync with the experience of the bereaved. Figure 2 illustrates the fit of the timeline and task orientation.

The tasks are the challenges facing the bereaved during each phase. As an example, accepting the reality of the loss is the challenge during the shock phase. The second task of experiencing the pain is the work of the disorganization phase. The adaptation to a new environment is the transition between the disorganization and reorganization phases. Finally, the reinvesting of emotional energy and the reorganization phase meld nicely.

The following information helps the therapist organize the approach of using the timeline and task orientation to have an integrated view of the process.

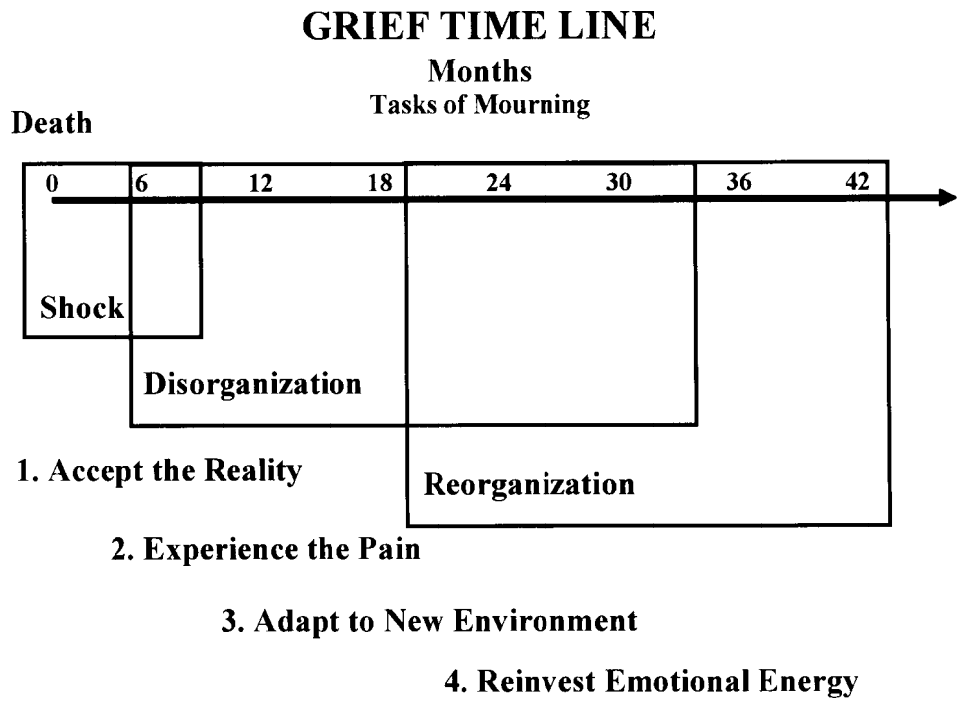

FIGURE 2. Four tasks of mourning.

First Task of Mourning

The first task of mourning is accepting the death and the loss (Worden, 1991). This is a subtle process that is difficult to assess. The individual may first talk about the deceased in first person. As the acceptance of the loss begins, the past tense may be more frequently used. The family also develops a shared acceptance of the reality of the loss. Family members slowly incorporate the deceased in conversations. The deceased's possessions are a helpful barometer. The individual may first link the loss to an object, then use the object as a symbol of the loss or transitional object, and finally place the object in a safe place as a treasured keepsake (Worden, 1991). For example, immediately after a death the bereaved person may hold onto a possession of the deceased. At first, he or she constantly carries this with them and is upset if it is misplaced. As the grief progresses, the bereaved person is able to separate from the object but knows where it is and how to gain access to it quickly. Finally, the object is put away in a place for safekeeping.

It is important to understand that the acceptance of the death is an ongoing process, not an end point. The bereaved will experience the loss on some level throughout his or her entire lifetime. Survivors of expected deaths may accept the loss sooner than survivors of unexpected and sudden deaths (Parkes & Weiss, 1983).

Systemic Interventions

Maintaining a focus on the context of death helps the therapist to join and form a supportive relationship with the bereaved that reduces their isolation. While individuals and organizations in their context either minimize or deny the death and grief, the therapist adopts a position of acceptance and closeness. Sophisticated interventions are not required. It requires that the therapist be comfortable with the expression of denial and subsequent intense pain by the bereaved. This relationship with the therapist needs to offer a safe place to express this pain.

Bereavement therapy is demanding. The therapist must tolerate intense emotional expression of family members' feelings of powerlessness when faced with unspeakable tragedy and loss. The therapist can also experience this feeling of loss of control. When this occurs, many therapeutic approaches direct the therapist to reduce the intensity. While this familiar approach helps the therapist maintain his or her own safety net, it can hinder the therapeutic encounter.

During these initial sessions, the therapist also supports and educates the bereaved. The therapist educates the bereaved about the context of death and the grief process. This is done because the bereaved person has most likely had little education on the extent of the grief process. The key points are to normalize the indicators of grief and give permission to grieve.

The picture session is an important systemic intervention (Hunsberger, 1984; Lawrence, 1992). The deceased needs to be included in therapy. After allowance of time for joining, each individual is requested to bring four to five pictures to the session. Every picture tells a story and it is the therapist's task to use these photographs as a tool to acquire information about the family. It is a powerful event for a family member to bring personal photographs of the deceased to a therapist. They often do not appreciate that they have completed this assignment successfully. They have shared photographs of their loved ones requested by a virtual stranger. A few weeks before they may not have been able to talk about the deceased. This process is the first step to help the bereaved gain a sense of mastery over death.

Clinical Case Examples

Ms. S is a 47-year-old office manager. Her husband of 8 years died while the couple ate lunch in a restaurant. He was recovering from recent heart surgery for a congenital heart condition. Three months into the grief process, Ms. S came into therapy with their adopted seven-year-old daughter. Her daughter had a history of behavior problems that they were working on in a previous therapy. She presented with concerns regarding the grief process and how she was feeling overwhelmed functioning as a single parent with this demanding child.

Identifying Ms. S's early position on the grief timeline, the framework guided the therapist to develop the following interventions:

1. Provide a safe environment to talk about the depth of her feelings. She felt pressure from relationships in her context to remain silent and there was limited recognition of her grief.
2. Provide an outline of normal grief for her to compare her experience.
3. Give permission to grieve and acceptance of the range of feelings, and to ask others to listen.
4. Reinforce the need for continued firm and consistent limits for her daughter.

Second Task of Mourning

The second and most difficult task of mourning is to experience the pain (Worden, 1991). The individual has progressed through the shock phase and they start to accept that their loved one is not going to return. The bereaved is most likely faced with expectations from others that they should be over it by now. The fact is that they are now face-to-face with the most intense emotions in the grief process. It is no coincidence that this task and phase occur at the time when most people enter bereavement therapy.

It is crucial that the family share in the expression of pain to accomplish this task. A family member may not participate in the shared expression of

pain through disallowing feelings and/or dysfunctional or unhealthy behavior. This can disrupt the family process of experiencing the pain. Helping family members accommodate to the differences in expression and timing of grief reactions is key to the successful negotiation of this task.

Systemic Interventions

In the disorganization phase, experiencing the pain is paramount. The therapist attends to the individual and family levels. Continued contact throughout the difficult and emotionally demanding disorganization phase is crucial. The basic framework for guiding the contact is:

(a) reduce the isolation,
(b) provide an environment that allows expression of all emotions,
(c) promote the transition to the next stage of individual and family development,
(d) restore order in the family with developmentally appropriate, firm and consistent limits with children.

At the individual level, the task of the therapist is to foster an environment in which the bereaved can feel comfortable to express unspeakable feelings. This requires a safe place and permission to express all of their feelings. It is imperative to continue to discuss details of the death, funeral, and relationship with the deceased. When working at the individual level, patience is required because the bereaved may repeatedly review difficult aspects of the death and/or their relationship.

Each person's grief happens in a family context. It is important for the therapist to take an active leadership role in helping the parent(s) to promote shifts in hierarchy and flexible boundaries. This unremitting attention to grief in context creates room for the individual grief while attending to the survival of the family. The importance of roles is highlighted. Extended family or community relationships play an important role in supporting the grief process.

As the individual and family progress, the therapist needs to support and validate their looking toward the future. Family members may often feel uncomfortable with feeling better. The therapist helps place this transition in context as a normal phase of the grief process.

A person experiencing a tragic, unexpected death including suicide or violent death, may take a longer time to enter this phase. When this occurs, the bereaved receives pressure from their context and themselves to get over the death. This can create a high level of anxiety at a time when the bereaved expects and is expected to move on with their lives. The bereaved should have the opportunity to work as long as they need to progress through the grief process.

Clinical Examples

Ms. D is a 67-year-old grandmother whose 40-year-old daughter died of a heart attack during her second ER visit in one evening. She was sent home after the first visit with the diagnosis of GI distress. She returned later in cardiac arrest and died within 1 hour after being admitted. Ms. D entered treatment 8 months after the death due to her own unstable emotional state and her concern about her two grandchildren, Kelsy 15, and Kevin, 12. Kelsy exhibited several concerning symptoms, including withdrawal, and isolating herself in her room and refusal to wear any clothes that were not at least two sizes too large. The latter was later connected to the fact that her mother was a buxom woman who often wore tight fitting clothes.

Ms. D herself was angry, scared, and she felt overwhelmed by the prospect of having to raise the children of her divorced daughter by herself. Ms. D was seen alone to process her grief experience and to plan strategies to support the granddaughter in her difficult grief reaction. Fortunately, her daughter was a very effective parent and she had few behavior problems with the children. However, due to Ms. D's emotional state she felt unable to provide the structure and to set limits for the children. The disorganization of the family was the first area for intervention. The therapist supported her in setting clear limits and to provide the opportunity to include the death in their daily conversations. The children were assured that Ms. D could handle their input about their mother and to share their grief, a process that occurred slowly over a period of several months.

Third Task of Mourning

The third task of mourning is adapting to the environment where the deceased is missing (Worden, 1991). The adaptation to the loss starts at the time of death. This task serves as the transition from the disorganization phase to the reorganization phase. The progression from shock to confusion now emerges into a realization of what changes the death has created for the individual and family. The loss is highlighted by the changes in the practical, everyday routines. This adaptation process requires new individual and interpersonal patterns to be established. This means new responsibilities and changes in lifestyle while grieving the loss. The family must be able to cope with disorganization while working to realign relationships and delegate new family roles.

Systemic Interventions

The therapist now shifts to actively challenging the bereaved to organize new behavioral patterns. This is accomplished by helping the bereaved assume responsibilities, take risks into new areas and activities, and to become

aware of how the practical aspect of day-to-day living mirrors their grief process. The family simultaneously experiences the grief and begins to more effectively adapt to the changes. The family defines the new roles and responsibilities and a shift in boundaries helps begin to promote adaptation.

Clinical Examples

During a support group for survivors of recent deaths, Ms. V, whose husband died over a year ago, spoke about a recent night out with her friends. This was her first venture out of the house since her husband's death. She returned home late in the evening and was struck with the fact that the house was dark. Her husband would have been driving her and he also always left the lights on for their return. This new and unfamiliar event provided her with the realization that the loss of her spouse of 35 years meant she had to adapt her environment in a practical manner.

Fourth Task of Mourning

The final task of mourning is the reinvestment of emotional energy in relationships with the living (Worden, 1991). The individual turns their attention to reestablishing intimate relationships. The bereaved still has room for the deceased in their everyday experience but their focus is now expanding the other facets of their life.

At the family level, the deceased is included in family life. This process is particular to each family based on the role of the deceased and type of death. The family assigns the deceased a place in their world. The loss has less of an impact on the daily functioning of the family.

Systemic Interventions

The therapist's work centers on continued coping with the loss and promoting an expanded social network. The direction is to help the bereaved to reestablish the relationship with the decreased in a form that allows new relationships to be established. The therapist also focuses on the guilt feelings of the bereaved for moving on without the deceased. The bereaved finds a unique way to include the deceased in their daily life while building other relationships.

Clinical Examples

Mr. R's 31-year-old wife, while driving home after leaving their 4-year-old son at daycare was hit broadside by a teenager drag racing. Her 5-month-old son was uninjured, but she died instantly. The family entered treatment 9 months after the accident. At 18 months after the death, the father was utiliz-

ing occasional sessions for support. The last sessions revolved around the father's new relationship. He met a divorced woman with two children and it quickly became a serious relationship.

The therapist punctuated the father's shift from his relationship with his deceased wife to his new partner. This included dealing with the feelings of disloyalty contrasting with the need for a new relationship for himself and a mother figure for his three children. This complex process included the blending of the families leaving a respected position for the surviving children's mother while creating a new family structure.

THE THERAPIST'S PERSONAL CONTEXT

Therapists involved in working with the bereaved face the difficult task of being with clients that are struggling with loss and grief. It can be said that all mental health work includes being with clients experiencing pain but grief work is unique in the permanency and depth of the loss. It is important for the therapist's own context to include a professional and personal support system. The professional support network can include targeted supervision, connection with colleagues who do similar type of work, and membership in professional societies specializing in working with death and dying issues.

The personal network starts with the therapist having faced the issues of grief and loss in their own lives. A therapist providing grief therapy does not need personal experience with loss. What can be helpful is for the therapist to have an awareness of his or her own struggles with death. This is to suggest that the therapist be aware of how these personal feelings and struggles inform the therapy process. A personal network can be helpful to provide support to the therapist. It is the times when the therapist starts to look over their shoulder thinking that something is to happen to them (e.g., excessive worrying about themselves and family members) that the support system can add some important perspective. The compassion and energy required for this work dictates that the therapist develop a supportive network.

CONCLUSION

A framework was presented for adapting a family systems approach to the grief process. This framework places the bereaved and therapist in the larger context. Tuning into the context that surrounds each death and using the grief timeline to facilitate timely systemic interventions are fundamental activities. This person-in-context focus helps the therapist navigate pitfalls and remain strategically positioned to sensitively and effectively address grief in psychotherapy.

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