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PROCESS AND CHANGE IN PSYCHOTHERAPY SESSIONS WITH A GRIEVING INDIVIDUAL: A THEMATIC ANALYSIS OF SYSTEMIC THERAPY

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Process and Change in Psychotherapy Sessions with a Grieving Individual: A Thematic Analysis of Systemic Therapy

Yastaki Bireyle Yürütülen Psikoterapi Seanslarında Süreç ve Değişim: Sistemik Terapinin Tematik Analizi

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ABSTRACT

This is a qualitative single case study of individual therapy process conducted with a grieving woman. The aim of the study was to investigate the process and change in psychotherapy sessions with a grieving individual. A total of 7 sessions were selected and examined in detail the attain the aims of the study. Thematic analysis was used for coding. The analysis revealed four main themes, namely 1) feeling the loss of the husband, 2) emotional responses to the husband's death, 3) increased self-awareness, 4) showing agency. The first theme includes four sub-themes of remembering hospital stay and feeling desperate, nightmares about husband's death, being a single mother and good memories in the past. The second theme consisted of anger, guilt, feeling overwhelmed and fear of loss. Childhood experience and seeking for change, new perspectives and understanding, positive thinking were the sub-themes of third theme. Finally, emotional resilience, thinking about re-establishing relational boundaries and mandatory vs. free choice were explained under the fourth theme. Results were discussed with the current literature, along with their therapeutic implications and limitations of the study and suggestions for future research.

Keywords: grieving, systemic therapy, Thematic Analysis, case study

ÖZET

Bu araştırma yetişkin bir kadın ile yürütülen bireysel terapi sürecini inceleyen nitel bir vaka çalışmasıdır. Araştırmanın amacı, yas tutan bir bireyin psikoterapi seanslarındaki süreci ve terapi ile sağlanan değişimi incelemektir. Kalitatif analiz için toplam 7 seans seçilmiş ve seanslar araştırma sorularıyla bağlantılı olarak ayrıntılı bir biçimde incelenmiştir. Seansların incelenmesi ve kodlanması sırasında tematik analiz kullanılmıştır. Analiz sonucunda sırasıyla 1) Ölen Eşin Kaybını Deneyimlemek, 2) Eşin Ölümüne Verilen Duygusal Yanıtlar, 3) Öz Farkındalığın Artışı, 4) Kişisel Eylemlilik olmak üzere dört ana tema ortaya çıkmıştır. Birinci tema, hastanede kalış ve çaresizlik hissi, eşin ölümüyle bağlantılı görülen kabuslar, tek başına ebeveynlik deneyimi ve geçmişteki güzel anıların hatırlanması olmak üzere dört alt temadan oluşmaktadır. İkinci tema öfke, suçluluk, bunalmış hissetme ve kaybetme korkusu alt temalarından oluşmaktadır. Üçüncü temanın alt temaları; çocukluk deneyimi ve değişim arayışı, yeni bakış açıları ve perspektifler, pozitif düşünmedir. Son olarak, dördüncü tema altında duygusal dayanıklılık, ilişkisel sınırları yeniden ele alma ve zorunlu ve özgür seçimler alt temalarından oluşmaktadır. Araştırmanın sonucu mevcut literatür ile birlikte, bunların terapötik etkileri ve çalışmanın sınırlamaları ve gelecekteki araştırmalar için öneriler ile tartışılmıştır.

Anahtar kelimeler: yas tutma deneyimi, sistemik terapi, Tematik Analiz, vaka analizi

CHAPTER I: INTRODUCTION

1.1. THE CONTEXT AND THE PURPOSE OF THE STUDY

Grief is a normal, complicated, and dynamic process that relates to individuality and uniqueness in terms of reactions to loss (Çelik & Sayıl 2003). A loss is an uncontrollable external occurrence that changes one's belief system and cognitions; as a result, a cognitive and behavioural adaptation to the effects of death is necessary (Enez, 2017). Loss causes grief and distress, since grief is a unique process of reactions after a loss, there are different theories about grief. Although grief is universal, the expression of grief is both individual and cultural. “Grief and the expression of grief is an articulation not only of loss but potentially of gain, growth, and the birth pangs of a new personal synthesis” (Corless et al., 2014, p. 132). It’s worth noting that “there is no one right or universal way to experience or respond to loss” (Rubin et al., 2012, p. 20).

Systemic therapy, which inspires therapists in their work with individuals, was born out of a sequence of study, consultation, and therapy sessions with families and couples (Boscolo & Bertrando, 1996). Thus, systemic therapy aims to explore the complex nature of the client’s world in terms of her/his ideas, emotions, people, environment, previous generations, and culture which refers to the system that s/he lives in. Since a systemic therapist's thinking is based on the idea of complementarity of lineal and circular causality, the importance of a diversity of points of view, and the privilege of asking questions over providing answers, it has the effect of transmitting to the client a way of connecting things and people, events, and meanings over time, allowing him to break free from a rigid vision of himself and his internal reality (Boscolo & Bertrando, 1996). As a result, the client's sensitivity may be expanded and deepened, and s/he may be more open to the new perspectives and experiences in her/his life from a different point of view.

The literature mentions that a death in the family is, "not only a personal tragedy but is also an assault on the integrity of the family system itself." (Westcott, 1985, p.17). A Bowen family systems perspective on loss considers the impact of

an individual's death on the family as a functional unit; a unit in which each member's coping and development is manually dependent, so any loss will have instant and long-term ramifications for all members and all other connected relationships (Bowen, 1978). Thanks to Bowen's family systems theory, we can provide an expanded understanding of the variations in the grieving and recovery process from death and loss for different families and family members. Consider the functional relevance of the family member who has deceased or is risking death, as well as the emotional maturity differences that each family inherits, to enable a professional to bring deeper knowledge and compassion to the helping process (Brown, 2012). The opportunity and privilege of working in the context of grief are frequently regarded as a wonderful gift for professionals who choose to care for persons who are dying or mourning. The common feeling is one of thankfulness for the opportunity to assist and support individuals and families dealing with end-of-life difficulties in all of their complexity. Such work is likely to be life-changing, providing an opportunity to support and perhaps improve the death and dying experiences of others while enhancing and affirming one's ability to treasure the mundane as well as the magnificent (Becvar, 2001).

As Becvar (2003) states that family therapists who assist those who are grieving or dying make a significant commitment to their patients, and in order to be truly effective, they must participate in that commitment. As a result, among the many strategies and suggestions for both institutional and self-care, a focus on body, mind, and spirit is pervasive. When the therapist abides by this advice and not only seeks improvements within broader systems but also searches for herself or himself, life is treated with the same honor and respect as death. (Becvar, 2003).

Killian (2016) states that as helping professionals, we can help clients form coherent, healing narratives while remaining aware that members of the same family may pursue very different narrative paths to reclaim a lived synchronization with caring for others, to engage no longer ambiguous losses, to begin to mourn, and to imagine a once foreclosed future.

Considering that one of the most important dimensions of mourning and death is the cultural dimension of mourning, the family system constitutes the first

nuclei of the grieving experience. Gamble (2002) promoted that since family therapists and other professionals can achieve, including greater tolerance for self, others, and life. Therefore, despite the challenges and associated vulnerabilities likely to arise in the realm of death, dying, and grief, the ultimate potential impact is the sense of balance and peace that death is one of the issues that family therapists will have the most impact on the family system if they dare to work. This condition of being, the gift of work in the face of grief that is available both emotionally and professionally, has been defined in a variety of ways and is a jewel with many aspects (Becvar, 2003).

Since grieving is a unique and personal process and includes expressions including verbal responses, each individual express differently her or his grief. Thus, this study aims to explore an individual's experiences of the grief process during systemic psychotherapy after the loss of her husband, from the systemic theory perspective including the griever's expression of grief and PRN MFT data.

1.2. UNDERSTANDING GRIEF AND BEREAVEMENT

Grief is a natural phenomenon that follows the death of a loved one. Grief is derived from the Latin word gravis, which means "heavy," and from which grave, gravity, and gravid are derived. We use the term gravitas to describe a trait in some people that allows them to bear the weight of the world with dignity. So, it is when people learn to carry their pain in a dignified manner (Weller, 2015).

Bereavement means "to be robbed" or "to be deprived of something precious" It usually alludes to the death of a significant person in our culture. Bereavement is defined as the experience of losing a loved one due to their death, which is related to mental and physical health problems, as well as an increased risk of the bereaved individual dying (Stroebe et al., 2007). Bereavement can manifest itself in a variety of ways, such as funeral services or a withdrawal from public activities (Thompson, 2016).

As Weller (2015) mentions that everyone is touched by grief and loss. The many tributaries of sadness come into the room when we join in the community for

a grieving ritual. They whirl about us, reaching out and touching everyone in the circle. We listen as the faces of loss are named: the death of a partner, a child, or marriage; a parent or sibling's suicide; cancer's cruel consumption of life; a home lost through bankruptcy; destroyed childhoods filled with alcoholism, abuse, and neglect; the lingering scars of those who fought in wars; chronic illnesses that depress and debilitate; lives lost to addiction; and a prevailing sorrow for our struggling world.

Grieving is a process that refers to the psychological aspects of bereavement or the feelings triggered by a profound loss, particularly the suffering experienced when a loved one passes away (Thompson, 2016). However, grieving is a complicated phenomenon since the process includes both common and subjective reactions in terms of emotions, feelings, thoughts, and practices. People can express their grief in subjective o culture-related manners and actions in the mourning phase. Grief is such an individual process, varying from person to person and moment to moment, and encompassing so many aspects of the bereaved's being at the same time.

There are different theories about grief. The original “grief work” hypothesis presented by Sigmund Freud comprised cutting ties with the deceased, adjusting to new life circumstances, and forging new relationships. Grief, according to Kübler-Ross, goes through a series of stages as follows, in order of shock and denial, anger, resentment and guilt, despair, and acceptance. Grief is a process of oscillation between two modes, according to Stroebe and Schut, a “loss orientation” mode when the griever participates in emotion-focused coping and a ‘restoration orientation' mode when the griever engages in problem-focused coping. Chronic grieving was linked to pre-loss dependency and resilience with pre-loss acceptance of death, according to Bonanno et al, but Neimeyer and Sands stated that the main challenge in mourning was the formation of meaning.

1.2.1. Freud’s Mourning and Melancholia

Freud's seminal paper, Trauer und Melancholie (Mourning and Melancholia), was published in 1917 after being studied by him as early as 1914 and drafted in 1915. (Boulanger, 1987; Gay, 1988; Gilbert, 1992; Hearty, 1989; Jackson, 1986). In it, Sigmund Freud compared the normal expression of grief, which is associated with mourning, with the aberrant mechanisms that are associated with melancholia. Freud also proposed a paradigm to account for both illnesses' origin, maintenance, and working through o both conditions (Dozois, 2012).

While mourning and melancholia are symptomatically similar, the principal distinctive feature of the latter condition is self-reproach: This picture becomes a little more intelligible when we consider that, with one exception, the same traits are met within grief. The fall in self-esteem is absent in grief (p. 153). In mourning the loved-object no longer exists and the world becomes poor and empty; in melancholia it is the ego which becomes poor and empty and one part of the ego (the conscience) begins to critically judge the other part. Grief and depression were also postulated to differ in that the loss precipitating mourning is external (i.e., there is an obvious explanation, e.g., death) and dealt with within consciousness; the object-loss in depression, on the other hand, is more symbolic and unconscious. Moreover, although grief sometimes involves grave departures from the normal attitude to life (p. 153), it is the normal reaction to the loss of a loved person: "it is really only because we know so well how to explain [mourning] that this attitude does not seem to us pathological" (p. 153). Melancholia is more difficult to explain and its provoking conditions extend beyond loss through death to include being wounded, hurt, neglected, rejected or disappointed which can bring opposite feelings of love and hate into the relationship or reinforce existing ambivalence (p. 161).

The work of mourning necessarily requires the gradual withdrawal of libido, which was previously attached to the loved object. Because the lost thing is still represented in one's memory, this procedure takes a long time and a lot of cathectic

energy. When the ego is free and unrestrained again, the process is complete and the ego can be transferred to another love object. In melancholia, a distinct process is thought to be at work, beginning with the first connection of libido to a specific person. Narcissistic identification determines one's love object and considerable ambivalence (defined by love/hate feelings) toward the object is also obvious. The object relationship is then shattered as a result of damage, disappointment, or rejection, resulting in libido release (Dozois, 2012).

Instead of being gradually withdrawn, this libidinal energy, combined with the anger felt against the lost object, is introjected onto the ego and exhibited in disease in order to prevent open hatred. Because of narcissistic identification with the love object, the free libido (and its related hostility) withdraws within the ego. The loss of the object is equated to the loss of ego as a result of this introjection. As a result, the melancholiac exhibits a lowering of self-regarding feelings to a degree that manifests itself in self-reproaches and self-rivilings, culminating in a deluded expectation of punishment. (p. 153). He or she also engages in moral denigrating, which manifests as insomnia, reluctance to eat, and suicidality (Dozois, 2012).

According to Freud's concept, three factors were required for the development of melancholia: 1) loss of the object 2) a combination of strong narcissistic fixation on a loved object and significant ambivalence, and 3) a libido regression into the ego (The first two are also present in grief, whereas the third is unique to melancholia).

1.2.2. Kübler Ross' Stage Theory

Elisabeth Kübler-Ross first proposed the Kübler-Ross model, also known as the five stages of grief, in her 1969 book *On Death and Dying.*

The 5 stages are;

1. Denial is usually simply a transitory defence. This is usually replaced by increased awareness of the conditions and people who will be left behind after death.

2. Anger: Whilst in the second stage, the person realizes that denial is no longer an option. Because of misdirected feelings of rage and envy, the person is extremely difficult to care for. Any person who represents life or energy is vulnerable to projected bitterness and jealousy.

3. Bargaining: The third stage involves the hope that the person will be able to postpone or prolong death in some way. Typically, a higher power is negotiated with for longer life in exchange for a changed lifestyle.

4. Depression: In during the fourth stage, the dying individual comes to terms with the fact that death is inescapable. As a result, the person may become quiet, avoid visits, and spend much of their time crying and lamenting. This procedure permits the dying person to disconnect from things that bring them joy and love. Attempting to cheer up someone who is in this stage is not suggested. It's an essential time to grieve and process your feelings.

5. Acceptance: In this final stage, the individual begins to accept their own or a loved one's mortality.

Kübler-Ross first applied these stages to persons who were dying of a terminal disease, then to anyone who had suffered a terrible personal loss (job, income, freedom). Significant life events may also be included, such as a loved one's death, divorce, drug addiction, the development of a disease or chronic condition, an infertility diagnosis, and a variety of calamities and disasters. These steps, according to Kübler-Ross, do not necessarily occur in the order listed above, nor are all steps experienced by all people, however she claims that everyone will go through at least two (Kübler-Ross, 1969).

Kübler-Ross' Model (1969) puts forward that importantly, those going through the stages should not rush the process. Grief is a highly individualized experience that should not be rushed or prolonged based on an individual's enforced period or opinion. It's enough to know that the phases will be worked through until the final step of "Acceptance" is attained.

1.2.3. Bowlby's and Parker's Four Stages of Grief

In the 1960s, psychoanalyst John Bowlby founded attachment theory. He explored the influence of separation and the events that cause us to feel dread and anxiety in his research with new-borns and young children and their mothers. He came to the conclusion that fear is triggered by elemental events, such as darkness, sudden movement, or separation. While these events may appear to be harmless in and of themselves, they do signal a higher chance of danger. Bowlby studied how young children react to the short or long-term absence of a mother figure, noting sadness, anxiety, protest, grief, and grieving. He established a new paradigm for understanding attachment and the impact of breaking attachment connections based on his discoveries (Bowlby, 1980).

Mary Ainsworth Bowlby, a psychologist, states that understanding a person's behaviour required an understanding of her/his environment. The child and parent, the patient and doctor, and the bereaved and bereavement therapist are all part of a mutually beneficial system in which one influences the other (Bowlby 1975; Wiener, 1989). The fact that we are influenced by other people, the food we eat, and the air we breathe is taken into account in this systemic approach. Grief, according to Bowlby, is an adaptive response that encompasses both current and past losses. He explained that it was influenced by environmental factors in the bereaved person's life as well as the bereaved person's psychological structure.

Bowlby and Parkes (1970, p.7) presented four main stages in the grief process:

1. Numbness, shock, and denial with a sense of unreality
2. Yearning and protest. It involves waves of grief, sobbing, sighing, anxiety, tension,

loss of appetite, irritability and lack of concentration. The bereaved may sense the presence of the dead person, may have a sense of guilt that they did not do enough to keep the deceased alive, and may blame others for the death

3. Despair, disorganization, hopelessness, low mood
4. Re-organisation, involving letting go of the attachment and investing in the future.

1.2.4. Stroebe and Schut's the Dual Process Model

The Dual Process Model of Coping with Bereavement (DPM) was proposed as a framework for understanding reactions to a loved one's death (Stroebe and Schut, 1999). From a cognitive stress viewpoint, the Dual Process Model of Grief (Stroebe & Schut, 1999) depicts grief as a fluctuation between two opposed ways of functioning. The griever engages in emotion-focused coping in the 'loss orientation,' investigating and expressing the variety of emotional responses related to the loss. At other times, the griever engages in problem-focused coping and is required to focus on the many external adjustments required by the loss, such as diversion from it and attention to ongoing life demands, in the 'restoration orientation.' According to the paradigm, the focus of coping might change from one instant to the next, from one individual to the next, and from one cultural group to the next.

The goal of creating a particular bereavement model was to identify the many ways in which people cope with the loss of a loved one. The DPM is distinguished by its combination of two types of stress, referred to as loss- and restoration-oriented stressors. Such stresses can be thought of as perceived worries, preoccupations, or burdens that must be acknowledged and dealt with in some way (Stroebe and Schut, 2016).

This brings the to the topic of coping. Coping refers to the procedures, techniques, or styles used to manage (reduce, master, and tolerate) the (perceived) predicament that grief places an individual in (cf. Folkman, 2001).

In 2016 Stroebe and Schut revised the model and added a component named "overload". In the original DPM, they only identified loss-oriented and restoration-oriented sources of stress. Then they consider that an essential missing link in the original DPM is something that is nicely represented in the term *overload*. Overload is characterized as a grieving person's perception of having more than he or she can handle—too many activities, events, experiences, or other stimuli (DSM, 2015). As a result, it includes, but goes beyond, the concept of bereavement

overload (the occurrence of multiple losses of loved ones in close succession, Kastenbaum, 1969).

1.2.5. Resilience to Loss and Chronic Grief

Bonnano et al (2002), evaluated major theories in the literature relevant to chronic mourning and resilience by identifying the pre-loss determinants of each pattern. Pre-loss dependency and resilience were linked to chronic grieving, as was pre-loss acceptance of death and belief in a just world. According to their study, findings show that the resilient pattern was the most common, while common grieving was infrequent. In addition; common grief, chronic grief, chronic depression, bereavement improvement, and resilience were identified as the five main grieving patterns.

According to Bonanno's research, before their spouse's death, those who had the most distress tended to have high degrees of personal dependency. Dependency was a major predictor of grief reactions in people who were not depressed before the loss. Increased distress was further compounded by the lack of expectation or psychological preparedness for the loss (2002).

Bonnano et al. (2002) claim that the wide diversity of grief patterns observed in their study shows that common beliefs about what constitutes an appropriate response to a severe loss should be reconsidered. The recent findings have a number of for future resilience research. Given the predominance of the resilient pattern in their current study, they suggest that it will be vital to learn how resilient people can digest loss so quickly and how they compare to resilient people who have experienced other types of life stress (Bonnano et al., 2002).

1.2.6. Task-Based Model

Worden proposed the Task-Based Model (2008). These models benefit both counselors and clients by providing frameworks for interventions that increase clients' self-awareness and self-efficacy.

According to Worden (2008), grieving should be viewed as an active process involving four tasks: (1) accepting the reality of the loss; (2) processing the pain of grief; (3) adjusting to a world without the deceased (including both internal, external, and spiritual adjustments); and (4) finding an enduring connection with the deceased in the midst of a new life.

Worden also identifies seven determining variables that must be considered to comprehend the client's experience. These are: (1) the identity of the deceased; (2) the kind of the attachment to the deceased; (3) how the deceased died; (4) historical antecedents; (5) personality characteristics; (6) social mediators; and (7) concurrent stressors. Many of the risk and protective factors discovered in the scientific literature are included in these determinants, which give a crucial background for recognizing the distinctive nature of the grief experience.

1.2.7. Grief Therapy and the Reconstruction of Meaning

Echoing Frankl's (1992) assertion that ''…the quest for meaning is the key to mental health and human flourishing'' (p. 157), constructivism is a postmodern psychological paradigm that emphasizes people's need to give meaning to their lives. (Neimeyer 2009). Meaning-making is an ongoing and participatory process in which the meaning of a loss can be confirmed or denied, consistent or contradictory, and supported or questioned within families and other reference groups (Nadeau, 1998).

According to a constructivist viewpoint, grieving is the act of putting together a new sense of meaning after a loss has torn apart the old one. A significant percentage of people suffer with long-term grieving and are unable to find meaning in the wake of an unexpected shift, even while the majority of people successfully navigate grief and retain or return to pre-loss levels of functioning. Constructivist therapists can help clients rebuild a coherent self-narrative that includes the loss while also allowing their life story to continue in new directions by employing a range of techniques (Neimeyer et al, 2009).

Neimeyer et al (2009) research indicates that for a significant amount of the population, the grief associated with loss might feel like a lifelong imprisonment. Grief may be the one stressor that affects humans almost universally. When examined via a constructivist perspective, the struggle to successfully incorporate the loss into the survivor's life narrative, in a way that maintains a thread of consistency and significance in the middle of a chaotic transition, is thrown into sharp relief. This point of view is supported by data showing how meaning building can adjust in the wake of loss, suggesting the necessity of meaning-based grief processing both during and between sessions.

For this reason, they (2009) put forward some constructive strategies in grief theory such as narrative retelling, therapeutic writing, metaphor, evocative visualization, and encountering the pre-symptom position.

1.2.8. Halls's Bereavement Theory: From Distress to Recovery

The traditional focus on an emotional journey from distress to 'recovery' has shifted in recent decades due to study evidence on the experience of grieving. Hall (2014) analyses how early stage theories of sorrow were dismissed, as well as more current theories that take into account the cognitive, social, cultural, and spiritual elements of grieving and loss. It goes on to discuss new developments in bereavement philosophy, grieving problems, and evidence for the effectiveness of grief therapies.

Hall (2014) claims that as the individual combines the lessons of loss and resilience, a loss can lead to life-enhancing 'post-traumatic' growth. Clinical research has increased our understanding of the unique symptoms, risk factors, psychological processes, and outcomes of mourning, resulting in more effective therapies for the bereaved. There is no such thing as a "one-size-fits-all" strategy or approach to mourning. Any interventions must be targeted to the individual, relationship, and circumstances that define a client at a certain point in time as they mourn a specific loss. Hall writes that (2014) when clinicians take a larger view of

grief and look beyond the experience of death, it becomes evident that grief is at the root of much of what practitioners in the helping professions face.

In addition, Hall emphasizes that there is a movement to continue bonds with the deceased one rather than say goodbye and let go. As Klass, Silverman, and Nickman (1996) suggest, after death, relationships with the deceased do not necessarily have to be severed, and there is a potentially constructive function for preserving continuous bonds with the departed. This concept indicates an acceptance that death ends a life, not necessarily a relationship. Rather than 'saying goodbye' or seeking closure, the deceased may be both present and absent (2014).

1.2.9. The Five Gates of Grief

Psychotherapist Francis Weller published his book entitled *The Wild Edge of Sorrow* in 2015. In his book, Weller writes that grief enters our hearts in a variety of ways throughout our lives. If people are to acknowledge and care for our loss, they must first become acquainted with what he calls the Five Gates of Grief. Each of these doors leads to the communal hall of mourning, and each enables us to comprehend the various ways in which loss affects our hearts and souls in this life. The five gates are;

1- Everything We Love, We Will Lose

2-The Places That Have Not Known Love

3-The Sorrows of the World

4-What We Expected and Did Not Receive

5-Ancestral Grief

For Weller, grief and love are sisters, woven together from the beginning. Their kinship reminds us that no love does not contain loss and no loss that is not a reminder of the love we carry for what we once held close. Alone and together, death and loss affect us all (2015, p.1) and he serves his book as prayer.

1.2.10. Anticipatory Grief

In contrast to mourning that happens during or after a loss, Aldrich (1974) described anticipatory grief as suffering that occurs before a loss. The idea that anticipatory grief lessened caregiver grief during mourning was cast into doubt by Nielsen et al. (2016), who conducted a systematic study of studies on anticipatory grief and found no evidence of a beneficial relationship between anticipating grief and loss.

Previously, Olsen (2014) claims that caregivers of cancer patients have an increased awareness of mortality and a lack of ability to plan for the future, which he refers to as "indefinite loss."

1.2.11. Complicated Grief

A group of mental health experts developed a diagnostic criterion for complicated grieving in a 1997 study. They provided the following diagnostic criteria to assist assess whether or not someone is dealing with complicated grief. Assessment Critea a (p.909):

A. Event criterion/prolonged response criterion Bereavement (loss of a spouse, other relative, or intimate partner) at least 14 months ago (12 months is avoided because of possible intense turbulence from an anniversary re-action)

B. Signs and symptoms criteria in the last month, any three of the following seven symptoms a severity that interferes with daily functioning Intrusive symptoms

1. Unbidden memories or intrusive fantasies related to the lost relationship

2. Strong spells or pangs of severe emotion related to the lost relationship

3. Distressingly strong yearnings or wishes that the deceased were there Signs of avoidance and failure to adapt

4. Feelings of being far too much alone or person-ally empty

5. Excessively staying away from people, places, or activities that remind the subject of the deceased

6. Unusual levels of sleep interference

7. Loss of interest in work, social, caretaking, or relational activities to a maladaptive degree

Kelly et al discovered (1999) that the main predictors of complicated grief were: 1) the carer's psychological symptom score at the time of referral; 2) the number of adverse life events; 3) the carer's coping strategies; 4) previous bereavement and separation experiences; 5) the carer's relationship with the patient, and 6) the severity of the patient's illness at the time of referral with patients with cancer.

Shear et al (2005) identified four major characteristics of complicated grief: 1) denial about the death; 2) anger and bitterness over the death; 3) recurring pangs of painful emotions with deep desire and longing for the deceased; and 4) preoccupation with thoughts about the deceased, which frequently include uncomfortable and intrusive thoughts about the death.

1.2.12. Spirituality and Good Death

Studies conducted with cancer patients show that as patients approach death, they begin to question the life they live and the meaning of life, this is also related to their spiritual well-being.

According to Murray et al. (2004), cancer patients and the people who care for them have high spiritual needs, including those for transcendence, love, and significance. Grant et al. (2004) found that the spiritual demands of cancer patients towards the end of their life were centred on a disintegration of roles and self-identity as well as a possibility of death. On the other hand, Becker et al. (2007) came to the conclusion that, due to methodological flaws in the studies, it was impossible to provide a conclusive answer regarding the place of spirituality in the grieving process and how it may be influenced by variables like age, gender, culture, and religion. Holdsworth (2015) examined and reported the end-of-life experience of grieving caregivers and identified six criteria that contribute to a "good death": “1) social engagement and identity connection”; “2) caregiver

personalities and actions"; 3) "caregiver confidence and ability to care"; 4) "death preparation and knowledge"; 5) "presentation of the patient at death"; and 6) "support for mourning caregivers after death".

1.2.13. Bereavement after Suicide

Bereavement after suicide differs from natural death bereavement. Research shows that the risk of psychiatric and physical morbidity may increase when the loss is due to a suicide (Clark & Goldney, 2000; Jones, 1987), however this finding is still debatable. Early analyses (Hauser, 1987; Henley, 1984) concentrated on qualitative suicide bereavement elements and typically came to the conclusion that it varies from other types of grieving. Recent clinically controlled quantitative comparisons imply that any differences are more likely to be qualitative than quantitative (Cleiren, 1991; Farberow, 1991; Jordan, 2001; Van der Wal, 1989). According to Jordan (2001), specific difficulties including the question of why the suicide occurred, remorse, taboo, and self-blame are characteristics of suicide bereavement (Silverman, Range, & Over- holser, 1994). Family conflict affects suicide survivors more frequently than those who have lost a loved one to a natural cause (Jordan, 2001; Jordan et al., 1993).

Groot et al.' (2006) research shows that chronic dysfunction following difficult loss is not unusual, which underscores the need to recognize at risk bereaved individuals. Self-reported psychiatric and general health of 153 relatives of 74 suicides was worse than that of 70 relatives of 39 natural deaths three months after bereavement. Even after adjusting for the likelihood of mortality, sociodemographic variables, and the neuroticism of family members and spouses, the former group still felt a greater need for professional assistance. This shows that those who have lost a loved one to suicide may represent a high-risk population of mourners who require specialized postvention. According to the study's findings (2006), persons who are grieving a suicide loss are less healthy than those who are mourning a death caused by an accident three months after their loss. According to recent findings, difficult grieving should be treated as a different clinical entity from

bereavement-related depression and was examined as a separate construct from depression (Boelen, 2005; Boelen, Van de Bout, & de Keijser, 2003; Prigerson, Frank, et al., 1995).

According to Tal Young et al. (2012) one of the most agonizing events in life is losing a loved one to suicide. Feelings of guilt, uncertainty, rejection, shame, anger, and the after effects of stigma and trauma frequently amplify the feelings of loss, sadness, and loneliness experienced after the death of a loved one among suicide survivors. Additionally, their research shows that (2012) survivors of suicide loss are more likely to have complicated sorrow, a protracted form of mourning, significant depression, and post-traumatic stress disorder, so survivors may need certain supportive measures and therapy to deal with their loss.

1.3. SYSTEMIC THERAPY

In the 1980s, there was a renewed interest in the individual and the inner world in the creation of systems theory and practice. Gregory Bateson's cybernetic epistemology has previously served as the foundation for the work of the majority of family and marriage therapists. Over the years, cybernetics has undergone a series of transformations, followed by the emergence of new ways of seeing and thinking, all of which have had a significant impact on the language, theory, and practice of family therapy (Boscolo&Bertrando, 1996).

Systemic therapy, which inspires therapists in their clinical work with individuals, evolved from a series of experiences in the study, consultation, and therapy with families and couples. From 1971 to 1975, we applied the Palo Alto Mental Research Institute's (MRI) strategic-systemic method (Boscolo&Bertrando, 1996). The Milan Systemic Approach was used for the next ten years, which was based mostly on Bateson's cybernetic epistemology. After 1985, the model was heavily inspired by constructivism and second-order cybernetics, followed by constructionism, narrativism, and hermeneutics. All of these theoretical contributions eventually left their imprint on our current model, which we would classify as both a systemic and an epigenetic model method (Boscolo&Bertrando,

1996). However, in the strategic-systemic approach, the therapist's purpose was to first ask the client to describe and decide which problems s/he wanted to resolve and then to study the client's and the major persons with whom he had relationships' previous unsuccessful attempts at resolution (Boscolo&Bertrando, 1996).

Karl Tomm (1987a, 1987b, 1988), who took a more explicit constructivist stance, borrowed and expanded on Boscolo and Cecchin's ideas regarding circular interviews. According to Tomm (1987a), systemic therapists are aware that they do not know everything and, as a result, must go on asking questions to gather new information and hypotheses for their therapies. As a result, he indicated that inquiries are therapeutic interventions in and of themselves. The primary purpose of circular interviews is to provide a fresh source of knowledge within the family, allowing for new insights into their interactions (Tomm, 1987a, 1987b). As a result, the dialogic process might be viewed as an intervention in and of itself (Tomm, 1988).

The Milan systematic method came to the United Kingdom in the early 1980s. David Campbell began his study in systemic therapy at the Tavistock Clinic in London, eventually becoming one of the leading proponents of the Milan approach in the United Kingdom with his group (Burck, Barratt, & Kavner, 2012; Campbell, 1999). Campbell defined his version of systemic therapy as three different ways of understanding what we see and hear: (1) it is based on an appreciation that what people observe around them can be comprehended in different and unique ways because any event can be seen from various contexts, each one giving different meaning for different people; (2) systemic thinking indicates an appreciation that there is a meaningful connection between a person's beliefs and their actions; and (3) systemic thinking implies an appreciation that there is a meaningful connection between a person's beliefs and what s/he sees is her/his construction, influenced by the interactions between her as a therapist and the members of the observed system. This is referred to as second-order cybernetics (Von Foerster, 1982).

One can observe how, throughout its constructivist period, systemic therapy turned away from first-order cybernetics' implicit behaviourism and toward a more

fundamentally cognitive attitude. Increasing information became the primary therapeutic strategy, with modifying clients' premises—the unconscious cognitive basis of our worldview, according to Bateson (1936)—as the primary goal. These prompted therapists to pay more attention to their clients' experiences and narratives, paving the path for future advancements (Loras, 2018).

The effectiveness of systemic family therapy (SFT) is determined by a complex combination and interaction of interconnected factors and variables. Rather than specific ingredients or interventions from specific models, common factors are the overall methods of change that cut among all effective therapies (Karam&Blow, 2020). There is evidence that these common factors account for far more variation in successful systemic family therapies than any particular model or individual approach (Blow et al., 2007; Sprenkle et al., 1999; Sprenkle & Blow, 2004a). The concept of common factors in psychotherapy is not new, with Saul Rosenzweig being credited with the original concept (Duncan, 2002a, 2002b). Common factors, in essence, question why psychotherapy actually does work and illustrate universal change mechanisms that cut across therapy theories (Karam&Blow, 2020). While the therapist is one of the common components that operates in the therapy room, the therapist can also increase other common factors that are present in every treatment session (2020). In addition, there are some extra aspects to consider with systemic family therapy, which will be discussed further down. Michael Lambert (1992) presented the following clusters, which were later adjusted by Hubble et al. (1999) and Wampold (2001) as they related to individual psychotherapy. These are therapist factors, client, therapeutic alliance, formalized feedback as an alliance enhancing factor, hope/expectancy and also which specific to systemic family therapy are conceptualizing difficulties in relational terms, disrupting dysfunctional relational patterns, expanding the direct treatment system and expanding the therapeutic alliance (2020).

Although John Bowlby's attachment work influenced a number of British and American family therapists, it was not widely accepted in the early years of family therapy practice (Bowlby, 1969; Ainsworth & Bowlby, 1991). However, as divorce, trauma, and violence rates continue to rise, there is a growing awareness

in the field of the complexities of human development. As a result, family therapists are revisiting early interpersonal theories of development in search of key therapeutic turning points (Hanna, 2018). Dr. Leslie Greenberg, professor of psychology at York University in Canada developed EFT. Greenberg and Susan Johnson began watching videotapes of their work during this collaboration, analysing the therapeutic process during times when clients seemed to have insights or breakthroughs that led to significant changes in their relationships (Hanna, 2018). Their research led to projects in which their techniques were compared to those of other couple therapy models. These findings prompted the formal development of EFT, a treatment program based on Bowlby's (1969) theory of attachment, separation, and loss (Greenberg & Johnson, 1988). Johnson's work, which emphasizes the power of emotion (rather than thoughts or behaviour) in relationships, brings together the best of what family therapy has to offer: sound interpersonal theory consistent interventions connected to theory and research about the therapeutic process and outcomes (Johnson et al., 2005).

1.3.1. Systemic Therapy with Individual

Different schools of treatment began to have a common pattern in the early 1980s. On the one hand, a number of individual therapists, including psychoanalysts, cognitivists, and Ericksonian therapists, began to express interest in family and couple therapy, with some drawing influence from strategic-systemic models. Similarly, numerous systemic family therapists who had previously focused on the relational structure between family or couple members began to pay attention to the members themselves, i.e., persons (and, incidentally, emotions). The epistemological shift brought about by second-order cybernetics and constructivism, which put the observer that is, the individual at the forefront, sparked this evolution in the field of systemic therapy (Boscolo & Bertrando, 1996).

Later, in the late 1980s, with its focus on language, social constructionism made it inevitable to go beyond the duality of an individual against the family. Further on, the theoretical frames that today motivate the work with individuals,

families, and other systems, such as narrativism, hermeneutics, linguistics, and conversational analysis (Boscolo&Bertrando, 1996).

The renewed focus on the individual demanded a reassessment of theory and practice, particularly among those working in the field of family therapy. For many years, family therapists focused on the individual's most important social context, the family. They were convinced that changing a person's family relationships was all that was required to transform him or her. The individual's inner processes were purposefully disregarded. This was owing to the intricacy and ambiguity of these processes, as well as uncertainties regarding their utility, because the presenting difficulties were assigned to external causes (relationships) rather than internal ones. Boscolo&Bertrando (1996) that the acceptance of the well-known "black box" notion (Watzlawick et al.1967).

For many years, the Milan group contributed to the exclusion of the individual's world by emphasizing the holistic components of Gregory Bateson's thought at the expense of other aspects dealing with the relevance of the inner world, the unconscious, and emotions (Bateson, 1972). Bateson wrote:

> "The individual mind is immanent, but not only in the body. It is immanent also in pathways and messages outside the body; and there is a larger mind of which the individual mind is only a subsystem. . .. Freudian psychology expanded the concept of mind inwards, to include the whole communication system within the body. . .. What I am saying expands mind outwards and both of these changes reduce the scope of the conscious self." (p. 467)

Bateson's immanentistic passion and resistance to all dichotomies can be seen in the following quote. This has had a huge impact on my thinking and working styles.

> "It is the attempt to *separate* intellect from the emotion that is monstrous, and I suggest that it is equally monstrous and dangerous to attempt to separate the external mind from the internal or to separate mind from body, (ibid., p. 470)"

For many years, the emphasis was focused on the "external mind," on observable interpersonal connections; nevertheless, in recent years, systemic

therapists have started paying overdue attention to the "interior mind." The therapist's and client's inner and outer worlds, as well as their relationships with the social structures in which they are embedded, have all become terrain to be explored (Boscolo&Bertrando, 1996).

In addition, Fran Hedges (2005) writes a book entitled *An Introduction to Systemic Therapy with Individuals: A Social Constructionist Approach,* and so she aims to support practitioners who work through systemic constructionist perspective with individuals. Her focus is mostly on the ideas of Milan Team as well as Bateson and Wittgenstein. Hedges (2005) mentions that relationships are the centre of systemic thinking because all parts of our social life, including our personalities, are considered as co-created across conversations and communication processes with other people including cultural and societal values. Thus, she gives a map for systemic therapists throughout her book to develop their skills in practice.

1.3.2. Systemic Therapy in Grief

In the 60s and 70s the field of family therapy began to develop and grow. (Becvar & Becvar, 2003), At the same time, the unmet needs of patients on their deathbed began to come into focus (Becvar & Becvar, 2003). With the progress of the developments in the medical field and the deaths in the hospital environment, the experiences of the patients who spent their last days in the hospital began to be a matter of curiosity (Vachon, 1999). One of the earliest examples was “International Work Group on Death, Dying, and Bereavement” took place in 1974. (Vachon, 1999). In addition, working groups and forums were established on the experience of death and mourning. They aimed to satisfy the needs of an expanding number of professionals working in this sector, “the Forum for Death Education and Counselling”, later known as the “Association for Death Education and Counselling”, was established in 1976. (Crase & Leviton, 1987).

Before the institutionalization of these formations about death and bereavement, some departments were opened in hospitals. At first, the notions of hospice and palliative care, introduced by Saunders (1959) in England. In the

United States, thanatology which is the field of psychiatry working with dying patients introduced by Kubler-Ross (1969) developed, announcing the beginning of a new movement.

However, some therapists and researchers claimed that denial and fear of death continued despite death became an experience in the hospital and medical process, and the researches in this area increased. While some clinicians still observed that death as a denied reality, some researchers claimed that death, along with sexuality, has been seen as a taboo, a forbidden subject to talk about in public, and even a disease. (Becvar,2003; Becker,1973; Foos-Graber, 1989; Shneidman, 1980 and Gorer, 1980).

According to Stiller (2001), conversations about this topic are still taboo, and "cultures go to enormous lengths to minimize reminders of our imminent mortality" (p. 2). Today, developments such as the rapid advancement of technology, the search for a cure for many deadly diseases, and the prolongation of life can be given as examples. Such denial efforts are obviously tied to concerns of death, a notion, and events that will always raise more questions than answers.

Based on this improvement, Becvar (2003) leads family therapists in encouraging them to work with clients who come with the experience of death and bereavement. Since death and mourning are a common experience that every person has or will experience, for her therapists should not hesitate to work on this issue. It has shown that individuals are very hesitant to discuss the challenging aspects of life, especially concerning absolute losses like death. This is evident and almost valid for most of people when one observes her/his own culture today. It appears that clinical research reflects this reality as well. Thus, therapists working with a systemic perspective should be genuinely part of working with death, as well as focusing on integrity of the body, soul and mind in addition to studying the larger system. Becvar (2003) claims that there are many ways to characterize this condition of being, which can be accessed both emotionally and professionally by working with grief.

Considering that one of the most important dimensions of mourning and death is the cultural dimension of mourning, the family system constitutes the first

nuclei of the grieving experience. Gamble (2002) promoted that since family therapists and other professionals can achieve, including greater tolerance for self, others, and life. Therefore, despite the challenges and associated vulnerabilities likely to arise in the realm of death, dying, and grief, the ultimate potential impact is the sense of balance and peace that death is one of the issues that family therapists will have the most impact on the family system if they dare to work.

On the other hand, Kylie Killian who is working with families with missing members and refugees focuses on ambiguous loss in his works (AFTA, 2022) Killian claims that a family member may suddenly vanish physically, leaving no trace of their whereabouts or status as living or dead, or they may deteriorate psychologically due to dementia or other mental or emotional conditions that cause what he refers to as the "death of personality.” So even within healthy families, it can be challenging to cope with an unclear loss in the world of grief and grieving (2016).

In other words, disintegration occurs in the world of meaning when the lover’s situation is ambiguous which means the entire family struggles to carry on (2016). It highlights people's ability to overcome hardship and recognises the opportunities and challenges that come with life experiences. So, according to him, (2016) helping professionals, such as therapists, should encourage the development of a unified recovery story for their patients, acknowledge the possibility that generations of family may follow very diverse narrative trajectories, and value others. In the situation of ambiguous loss, sorrow becomes difficult not owing to some psychological flaw or deficiency but rather because of the significant complexity of a loss shrouded in mystery (Boss and Carnes 2012). Therefore, Killian (2016) emphasizes the value of social support and resilience as a critical counterargument to the prevalent narrative on trauma.

1.4. ANALYSIS OF PROCESS AND CHANGE IN SINGLE CASE STUDY

Lysaker et al. (2017) aim to learn more about how psychotherapy can help people with early psychosis gain insight, they conducted a qualitative analysis of a

single case from a recent metacognitive reflection and insight therapy (MERIT) trial design randomized controlled trial (2017), in which all eight participants who completed the trial showed statistically and clinically significant improvements (Vohs et al., 2018). Other case studies (George & Buck, 2018; Hamm & Firmin, 2016; Hillis et al., 2015; Leonhardt et al., 2018) demonstrate MERIT helps individuals with EP integrate multiple lived experiences in more sophisticated ways. This is also in line with a number of recent international qualitative research, which imply that recovery is less about symptom reduction and more about sense making and agency (Thompson et al., 2019), as well as feeling that one's experience can be understood by others (Kamens, 2019).

Some of the information, procedure, and therapist behaviours that sparked or encouraged insight were expected to have happened right before insight emerged. To learn more about this, qualitative methods were used to pinpoint the content, procedure, and therapist traits that an EP patient displayed prior to and that seemed to support insight as well as the regularity with which insight and psychological issues surfaced. (Pattison et al., 2020)

Change process research, which was first presented over than 20 years ago, is defined by Elliott (2010) as "the study of the processes by which change occurs in psychotherapy, including both the in-therapy processes that bring about change and the unfolding sequence of client change" (Elliott, 2010, p. 123).

The idea that there are "common elements" that all therapeutic techniques share is one that was first put forth by Rosenzweig in 1936. Afterwards, Stiles, Shapiro, and Elliott (1986) proposed that numerous psychotherapy models' results are comparable and have the same effects despite the fact that there are evident differences between them (Lambert & Ogles, 2004; McAleavey & Castonguay, 2015; Wampold, 2001). There are therefore similar traits that lead to change in every therapy, regardless of the theory and technique used by the therapist. It seems that the topic of common factors has not received the attention it deserves in the field of systemic therapy (Davis & Butler, 2004; Sprenkle et al., 1999). While there appeared to be differences between different modalities, there was a focus on process variables that were common to all modalities and influenced all therapy

approaches (Connor-Greene, 1993). For many years, the focus of common factors has been critical change research process (Garfield, 1983; Lambert & Ogles, 2004; Lambert, 1992; Miller, Duncan, & Hubble, 1997; Patterson, 1984).

Despite the fact that therapeutic change appears to be a major concern, there is no empirical evidence of how change occurs in the therapeutic context in systemic therapy (Dourdouma et al., 2019). It is worth noting that systemic work does not always imply working with the entire family or system. The majority of therapists with training in systemic family therapy use systemic therapy in a range of contexts, including individual, couple, and group work. (Boscolo & Bertando, 1996). Main systemic techniques such as enactments, reframes, externalizing inquiries, paradoxical interventions, circular questions and other systemic interventions and strategies have prompted increased attention (Heatherington, Friedlander, & Greenberg, 2005). On the other hand, research shows that in particular, that the therapist's self also makes a difference and that his or her emotional capabilities, along with his or her knowledge and techniques, are described by participants as essential for therapeutic change (Dourdouma et al., 2019).

Although the process of change in therapy still maintains its importance as an academic and clinical question, recent studies have mentioned the importance of the therapeutic relationship. Considering the research investigating the change in therapy in the field of systemic therapy in recent years, the therapeutic relationship seems to be the key to change in therapy. Dourdouma et al. (2019) indicate that according to the client's perspectives, the therapist, the client, and the therapeutic relationship are the factors that play important roles in the therapeutic change in systemic therapy.

Furthermore, previous studies have mostly focused on what therapists do to facilitate therapeutic change, while little is known about the client's experience of treatment (Kuehl et al., 1990). So, Dourdouma et al.'s (2019) research findings suggest that clients' agency is critical to the therapeutic change process and illustrate that clients' motivation and personal work in therapy is important. Thus, the client's investment in the therapy process is one of the factors affecting the change.

Similarly, other researches show that change in therapy is related to both the therapist and the client which means it is important that client's agency to participate actively in the therapeutic process (Blow and Piercy, 1997; Flaskas and Perlesz, 1996).

Finally, the therapeutic relationship is defined as a very bring significant of therapeutic change that emphasizes reciprocity and collaboration. The therapeutic bond is thought to be a significant transformation process and therapy outcome. (Boscolo & Bertrando, 1996; Robbins, Turner, Alexander, & Perez, 2003; Sparks & Duncan, 2010).

In Turkey, marriage and family therapy is a fast-growing profession. Although the number of family therapy (or family counselling) trainings has increased in recent years, there is still a lack of standardization (Akyıl et al, 2015). It is critical to first gain understanding of the existing situation of those who practice in order to improve this profession. Using an online survey disseminated to web-based psychology groups and graduates of family therapy training programs, Akyıl et al.'s study aims to better understand the characteristics and clinical practices of clinicians who work with couples and families (2015). However, theoretical framework of therapeutic change processes in systemic practice with individuals, and empirical knowledge in this field appears to be thin on the ground.

1.5. PRESENT RESEARCH

Although loss and grief are universal for humans and there are some common responses and reactions after loss, the grieving experience is subjective and unique to each individual. Indeed, in the not-too-distant past, death was regarded as both a societal sickness (Shneidman, 1980) and a less appropriate topic of speech than sexual activity (Gorer, 1980). Stiller (2001) states that "cultures take great measures to minimize reminders of our eventual death" and that "conversations about this topic remain taboo" (p. 2). Such denial efforts are clearly linked to concerns of death, a concept and event that will always elicit many questions than answers (Becvar, 2003). Therefore, Becvar (2003) mentions that a

review of the family therapy literature shows that even fewer studies have looked at the influence of a focus on dying, and grief in the family therapy field.

On the other hand, there are a few exceptions that have been regarded as seminal contributions in the field of individual systemic psychotherapy: the work of Boscolo and Bertrando (1996), the methods proposed by Selvini Palazzoli and Viaro (1988) for the treatment of anorectic patients in individual settings, and the coaching approach of McGoldrick and Carter (2001). Aside from these models, there is a vast clinical literature that frequently refers to individual treatments in vignettes and case reports, but without exposing detailed methods for therapeutic process organization (Tramonti & Fanali, 2015). Few efforts have been made to connect the previously mentioned models, and we know very little about their role in shaping the work of systemic clinicians in both private and public settings (2015). Few attempts have been made to combine the previously stated models, and we know very little about how they influence systemic doctors' practice in both private and public contexts (2015).

Different concepts and viewpoints guide such strategies, with some focused on intergenerational family bonds and loyalty, while others are more strategically oriented in present and here of current relationships (2015). Some contributions place a special emphasis on dialogue techniques developed through family therapy practice and applied to individual treatments, and the growing interest in narratives has led to the socio-constructionist perspectives as the most appropriate declination of postmodernism for systemic-oriented therapists (Hedges, 2005).

The synthesis of all of these contributions raises problems regarding how a modern systemic epistemology should be understood, and, as a result, what types of interventions can be deemed coherent with such an approach, balancing the contributions of many but compatible sources (2015). In reality, the systemic-relational approach is well known for oscillating between the symbolic and interactive dimensions of relationships, and aiming to integrate features from both dimensions could pave the way to a comprehensive model for individual psychotherapy (2015).

In this regard, especially in Turkey, there are limited qualitative studies that concentrate on what individual's experience after a family member's death and change in their family system and how the expression of grief plays a role to show this change after loss and narrative changed related to the death and grieving. Also, there is no study which focuses on systemic working with individual. Selin Günkaya's dissertation project (2021) focused on learning more about the functions of dreams in bereaved individuals who have lost loved ones during the grieving process, as well as the impact of changing dream contents on the grieving process with 8 participants through phenomenological analysis method. It also seeks to learn more about the role of religion and spirituality in grief (2021). Also, İdil Biriken Gürses's dissertation project (2022) entitled *A Family's Changing Grieving Process During Family Therapy* focused on the constituents of the grieving process of a family. Hence, this single case analysis will contribute to the literature in terms of systemic therapy with an individual who wants to cope with her stress and pain after her husband's death.

This is a single case study that explores the uniqueness of the grieving process of an individual in the therapy sessions in which the systemic approach is the theoretical perspective. Since the uniqueness of the process and change is the main focus of the research, the case study is useful (Simons, 2009). A case study is a research approach that allows researchers to investigate close, in-depth, and extensive examination of a research topic (McLeod, 2019). Since the purpose of this study is to identify themes associated with bereavement in one's narrative and compare the themes within the sessions, the data was applied to Thematic Analysis.

Research Questions:

a. What are significant themes in the systemic therapy process with a grieving individual?
b. How do themes in systemic therapy with a grieving individual evolve over time?
c. How do the client's individual and relational symptoms change over time during systemic therapy?

CHAPTER 2: METHOD

2.1. PARTICIPANT

2.1.1. Client

A woman, 41 years old, retired from the bank and has three children. Her husband died by suicide after a psychotic attack. She decided to get therapy for talking about her suffer after the bereavement.

For confidentiality, the identifying information was changed or hidden. The assumed name was used in the thesis. The permission about using the therapy data was taken by the participant before the therapy process. Following the ethics board approval, the informed consent form was given to ensure voluntariness for the dissertation. If the client wants to withdraw from the research until the dissertation is published, the research will be cancelled.

Zoom was used to record videotaped data, which was then saved in a password-protected subdirectory on the computer. The researcher transcribed the videotaped data. The transcripts have been stored in a password-protected computer folder as confidential. The transcripts and consent forms will be kept in a protected folder on the researcher's computer for five years after the thesis has been approved.

2.1.2. Presenting Problems, Systemic Case Formulation, and Therapy Objectives

The client's spouse committed suicide 6 years ago, and the grieving process that followed and the difficulties of being a single parent have been affecting the client's daily life for the last 5 years. She stated that with the pandemic and the ensuing quarantine period, the client was getting tired of struggling with the responsibilities and looking after children alone. Staying at home has greatly increased their complaints and made them visible. First of all, she decided to get

support from the child-adolescent department for her youngest son. When the psychologist who conducted the interview also recommends individual therapy to her, she decides that she also needs therapy and that she has emotional difficulties and applies for therapy.

The client stated that her emotional difficulties and unhappiness have been going on for a long time. They have been married for 5.5 years and they have 3 children from this marriage. Her husband's bipolar disorder, treatment process, and side effects of psychiatric drugs forced her to struggle alone before and during the marriage process. After the death of her husband, the client mentioned that she felt obliged to be strong for her children and postponed the grieving process. Later, the nervous breakdowns, outbursts of anger, and gaining weight pushed the client to seek help. However, because she could not connect with the therapist, she ended her first process after 4-5 sessions.

Along with the quarantine period, the client stated that her difficulty in allocating time for herself, she could not spare time for herself between children and housework, and her social environment was very limited. This congestion causes her to have bursts of anger and she states that she felt overwhelmed at the end of the day. Considering the relationship of the client with her family, it was observed that she could not develop close relationships with her parents from her childhood and could not find a safe environment to express her feelings and needs. She described her father as dominant and her mother as quiet. She stated that she has had a weight problem since she was a child, so she was bullied by her brother at home and mocked and bullied by her friends at school. She added that because she cannot share these difficult experiences with her parents, she was a quiet, introverted person who built a wall against people, was afraid of expressing herself, and felt herself a victim. It has been observed that the client hardly maintained the need to take distance, which she experienced in her root family, and in her current relationships, and generally be quiet in order to avoid tension. She had also difficulties in establishing a romantic relationship and that she is afraid of her father's reaction. Her father's authoritarian attitude, not being able to see the closeness she demands from her mother, and her older brother's taunts made

difficult for her to trust the opposite sex and caused her to feel guilty and to blame herself for any negative situation she experienced in her romantic relationships.

Her past of abuse at age 7 and her mother blaming caused attachment injury. She stated that after this traumatic event, she always found herself in a disadvantaged position in her relations with people. This attachment injury she experienced with her mother emerged a pattern in which she remained silent in the face of her difficulties and felt guilty afterward. The trauma she experienced challenged the client's values such as seeking her rights, expressing herself, and protecting her boundaries. Also, she was very determined to transfer these values to her children, and among her motivations for coming to therapy, transferring these values to her children was her main goal. One of the main goals in therapy was to bring these values forward for client and to make her leave her victim position in her current relationships.

The client mentioned that her marriage was also challenging for her, that she had psychological disorders during the pre-marital period and during her pregnancy, and that she used antidepressants. She attributed her preference to marry someone with bipolar disorder to the fact that she has never experienced a romantic relationship before and to the underlying feeling of worthlessness. The client stated that she was very afraid of experiencing loss, especially after the death of her husband, and therefore she was nervous during the pandemic period. In the face of her needs and feelings that she could not express, she stated that she found a way to relax by eating uncontrollably or that she noticed tremors in her body that she could not control.

Among the current issues that kept the client quite busy about her relationship with her children, she said that she does not want to cause her children to experience the troubles she experienced as a child, but she expressed that she did not know how to behave and feels helpless. The therapy provided a space for her to realize what she carried from her root family to her current relationships and to make connections. To forge her own path as she becomes aware of experiences with her root family and unmet attachment needs in her past relationships; It has been observed that she was willing to work in order to create her own motherhood and

femininity values. The client attended the sessions regularly, trusted the process, and was motivated to express her challenging experiences. Although it was challenging for her, it was observed that the therapist's contribution to the secure relationship process she tried to establish was high. Even starting and maintaining a therapy process for oneself is one of the interventions of therapy.

Therapy objectives have been set according to systemic case formulation:

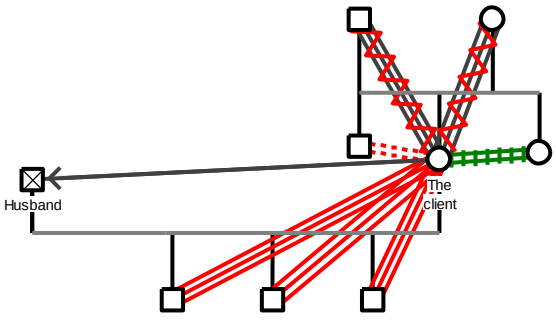
1- The client’s presenting problem is reframed in the context of attachment patterns and needs, by associating it with the feeling of worthlessness and root family experiences.

2- Addressing the mourning experience of the client in therapy by associating the difficulties experienced by the client in expressing her own needs and feelings with the fear of loss and loss experiences that became apparent with the suicide of her spouse.

3- Working on the client's outbursts of anger and subsequent feelings of guilt, together with the underlying feelings of loneliness and helplessness, and developing an alternative story in her relationship with both her own children and her own childhood.

Figure 2.1.

Genogram of the Client



2.1.3. Therapy Process

In the light of those objectives; in the initial stage of therapy therapist worked on building alliance with the client by focusing on her emotions, reflecting and validating experiences. These helped client to feel that she was heard in a secure place and so it facilitated the building of therapeutic alliance. Therapy can be described as an integration of systemic, emotionally focused therapy with individuals (EFIT) and narrative approaches. The core of EFIT, and a means to stay on track, is to continuously be reminded that the E.A.R. of EFT is the key to forming corrective emotional experiences for individuals. Follow EMOTION, concentrate on ATTACHMENT, and reshape engagement tactics. As Morgan (2000) mentions that narrative therapy is referred to as "re-authoring" or "re-storying" talks. Stories are essential to understanding how narratives function, as these descriptions imply. Therapist also focused on common factors in systemic therapy (Sprenkle, Davis, Lebow, 2003). In this regard, therapy process included the techniques and interventions such as building a strong therapeutic alliance, focusing on the triad cognition-emotion-behaviour through creating alternative meanings, slowing down the process and focusing on underlying emotions and underlining exceptions to dysfunctional patterns.

Later on, in addition to focusing and reflecting emotions therapist was holding and covering vulnerable emotions, especially regarding to her grief. In this time period, the client brought much her emotions related to her grief and she mostly suffered with guilt which was connected to her past experiences which came out in genogram session and supported by systemic reframing by the therapist.

After client has insight regarding the connection with her current problems and early experiences, therapist continued to make systemic interpretations to raise client's awareness about her coping mechanisms, her continued patterns from the childhood and her struggle with boundaries in her close relationships.

By means of circular questions and relational interpretations, client gained more awareness about her boundaries, she began to attempt for differentiation, she connected with her needs and expectations, made sense of her anger and she found

a secure space for sharing her vulnerable and heavy emotions especially about her husband's death. She began to restructure her life line in a more positive perspective by appreciating herself rather than blaming.

2.1.3.1. Self of the Therapist

A key component of becoming a successful therapist is the development of the therapist's own self. Several therapists have acknowledged that the most crucial element in creating a therapeutic connection is the use of self (Andolfi, Ellenwood, & Wendt, 1993; Baldwin, 2000). Virginia Satir spent a lot of time throughout her therapy training programs on this feature because she was a great supporter of the therapist's self (Lum, 2002). In order to recover and get ready to be therapeutically congruent, it's critical for therapists to handle unresolved family of origin issues. Therapists also have negative repercussions from prior occurrences, similar to how clients do with their clients. It's more probable that emotionally stable therapists have dealt with their own problems (2002). If therapists have not dealt with these problems, there is a good chance that they will respond to clients' problems in a variety of ways, such as being stuck, dodging the subject, distorting the facts, or losing concentration. Therapists can give their clients their complete attention while they are using self (2002).

The Person of the Therapist Model is founded on the idea that, at its foundation, therapy is a personal process that happens between the therapist and the client in a therapeutic setting. POTT further argues that therapists are capable of learning how to effectively and consciously employ themselves individually throughout the therapeutic process in order to give their patients the kind of treatment that is both competent and effective (Aponte and Kissil, 2016). POTT teaches therapists how to strategically employ all of oneself while paying close attention to their distinctive themes, which serve as the model's main supporting pillars. Two presumptions form the basis of the concept of the signature theme: One, every person has a certain psychological problem that underlies their human woundedness and colours their emotional and interpersonal functioning for the

duration of their life. Two, therapists must be able to selectively expose themselves in judicious vulnerability in order to feel and understand something of the suffering and challenges of their clients in order to relate to them most successfully (Aponte&Kissil, 2017).

Consistent with Self of the Therapist Model, during the therapy process, I regularly continued my own therapy process and supervisions in terms of getting more aware of my own self and differentiate them from the client's process.

2.2. PROCEDURE

2.2.1. Data Collection

The informed consent form has taken from the client before starting the therapy, the form is about recording the sessions and using those recordings for the supervision and psychotherapy research for the Couple and Family Therapy Track in Clinical Psychology Master's Program at Istanbul Bilgi University. Between the months November-September 35 therapy sessions have been conducted with the client. Due to the pandemic precautions, all sessions were conducted via Zoom and all recordings were done via Zoom and kept in a locked folder as confidential on the computer.

After Ethics Committee's approval, the primary investigator (PI) shared another informed consent form for the dissertation with the client who want to be in the therapy process and apply to the Istanbul Bilgi University's Counselling Center. The online consent form was made by using Google Forms, which includes information about the aim of the study, confidentiality, and asking about the use of the videotaped sessions for the dissertation, and the consent form is presented in Appendix A. The consent form has been shared with the participant via e-mail. After deciding to analyze the case for my dissertation research, I took another verbal consent of the client. The inclusion criteria are being a systemic therapy client, and dealing with a loss of a loved one; because the research also investigates the impact of systemic therapy on the grieving process. Though there are some

similarities between bereavement-related grief and major depression, they are separate and discernible conditions (Pies, 2014) the exclusion criteria are getting diagnosed with major depression and other related mental health diagnoses before the loss.

2.2.1.1. Quantitative Measures

The Practice Research Network in Marital and Family Therapy Platform was used to collect quantitative data (Johnson, Miller, Bradford, & Anderson, 2017). In PRN, the client completes a demographics questionnaire at the start of the session and indicates her presenting problems, and then she rates the progress, and therapeutic alliance every week, and then she rates her wellbeing (stress, anxiety, depression, emotion regulation), attachment anxiety/avoidance every four and then eight weeks. Out of all the assessments used in PRN, the following scales were applied in this research to comprehend each client's weekly and monthly progress as well as to analyse changes in the therapeutic process.

Demographics: All clients are required to fill out a demographic questionnaire at intake sessions, which includes standard inquiries about age, race, income, education, and marital status as well as inquiries about any current medical conditions, concerns, and previous treatment experiences. Clients also disclose mental and physical abuse and answer inquiries regarding traumatic experiences they had as children (Anda et al., 2006). (Johnson, Miller, Bradford & Anderson, 2017).

Weekly Scales: Clients are given the Presenting Problem Scale during the first session, and they choose their three leading issues to report. Then they rate their progress every week on a 7-point scale that ranges from "the problem is considerably worse" to "the problem is solved." Before each session, the client completes the 13-item Intersession Report (IR; Johnson, Ketring, & Anderson, 2010) to rate their development in the areas of anxiety, depression, relationship functioning, sleep, and exercise.

Assessment Packet: To evaluate the clients' development, individual symptom and relationship questionnaires were used. Before the intake session, every fourth session through the 16th session, and subsequently every eighth session, they were completed. The Patient Health Questionnaire (PHQ; Kroenke et al. 2001; Kaya, et al., 2019; Corapcioglu & Ozer, 2004) uses a 4-point Likert rating scale to assess depression and depression severity, and the Couple Satisfaction Index-16 (CSI; Funk & Rogge, 2007) evaluates a couple's relationship satisfactorily. Generalized Anxiety Disorder (GAD-7; Spitzer et al., 2006 Brief Accessibility, Responsiveness and Engagement Scale (BARE) was created by Sandberg et al. (2012) and Zeytinoğlu-Saydam, Erdem, and Söylemez (2002) to measure attachment behaviours in partner relationships. Difficulties in Emotional Regulation Scale (DERS) measures to people's difficulties with emotion regulation through six subscales: Nonacceptance of emotional response, difficulty with goal directed behaviour, Impulse control difficulties, Lack of emotional awareness, Limited access to regulation strategies, and Lack of emotional clarity.

2.2.1.2. Qualitative Measures

On the dates specified below (November-September 2020), 35 therapy sessions have been conducted. Upon Ethics Communities' approval, the researcher transcribed selected videotapes in which session texts are related to ongoing progress scales that show whether a change occurred in individual symptoms and presenting problems of the client and monthly progress scales (the scales that were filled in every 4 weeks) to analyses overall progress.

2.2.2 The Primary Investigator (PI)

The researcher is the tool of inquiry in qualitative research and evaluation, particularly in data gathering and process researcher's professional and/or personal experience, interests, and motivation for the project could have advantageous (e.g.,

facilitating access to research subjects, lending credibility to the interpretation of results) or negative (e.g., raising worries about potential bias) implications for the study (Corrall, 2017). From developing a study and studying the literature to dealing with data, debating the findings, and expressing the conclusions, the qualitative researcher must consider these challenges at every stage and aspect of their project (Corrall, 2017).

To strengthen the validity of the data and the report of a qualitative study, the researcher's position and perspective should be explained (Corrall, 2017). At the very least, the researcher should explain whether s/he considers- himself an outsider or an insider; whether s/he considers herself/himself an expert or a learner; and whether s/he is conducting the research on, for, or with the individuals in the context investigated (Blaikie, 2007). However, "good" qualitative research practitioners go beyond simple autobiographical description, including analysis of how their culture, gender, history, and personal experiences have shaped all aspects of their projects, from the formulation of questions to their expectations of outcomes (Creswell & Poth, 2017).

In other words, the researcher must "Be reflective and reflexive," monitoring her/his thought processes and decision-making criteria; being aware of her/his predispositions, biases, fears, hopes, constraints, blinders, and pressures; observing and learning about herself/himself, as well as her/his cognitive and analytical processes. Hence, as a Primary Investigator, I will take the precautions above-stated.

2.3. DATA ANALYSIS

This case study consisted of 35 sessions. Each session has been examined as a whole and each element re-examined separately to clarify particularly important words, meanings or themes that seemed especially revealing of grieving (van Manen, 2014). A thematic consensus-based approach is searching for and identifying similar themes extending across the set of transcripts (Vaismoradi,

Turunen, & Bondas, 2013). To start, PI independently read each therapy session and identified: (a) instances of insight or awareness of problems related to grief and (b) the similar patterns that the sessions follow in terms of talking about grief. The criteria for the chosen sessions that can be discussed together with PRN, for the purposes of this study the sessions below were choose for coding to understand monthly progress of client and also to interpret the change in the therapy process. Sessions 1, 4, 8, 12, 16, 24, and 32 were chosen according to the criteria.

2.3.1. Thematic Analysis

Thematic analysis is a method for examining qualitative data that comprises analyzing a data set for repeating patterns, understanding them, and reporting them (Braun and Clarke, 2006). It is a tool for descriptive analysis, but it also entails interpretation in the selection of codes and the construction of themes (Kiger and Varpio, 2020).

According to Braun and Clarke (2006), thematic analysis can be used as a stand-alone analytic tool or as a framework for different qualitative research methods. Indeed, the principles of thematic analysis, such as how to code data, uncover and refine themes, and present findings, may be used in a variety of different qualitative methodologies, including grounded theory (Watling and Lingard, 2012) and discourse analysis (Taylor et al., 2012). Braun and Clarke (2006) refer to thematic analysis as an approach rather than a more rigidly established methodology because of its flexibility.

When trying to comprehend a group of experiences, thoughts, or behaviours throughout a data set, thematic analysis is a useful and effective method to utilize (Braun and Clarke, 2012). Thematic analysis provides researchers with a great deal of flexibility in terms of: (a) the types of research questions it can address, ranging from personal accounts of people's experiences and understandings to broader constructs in various social contexts; (b) the types of data and documents investigated; (c) the volume of data analysed; (d) the theoretical and/or epistemological framework used; and (e) the ability to analyse data using an

inductive, data-driven approach or a deductive, hypothesis (Clarke and Braun, 2013).

Also, the significance or centrality of a theme is not always reflected in the frequency in which it appears in the data (Braun and Clarke, 2006; Nowell et al., 2017). Braun and Clarke (2006) discern between semantic and latent themes. Semantic themes (also known as manifest themes) reflect the more explicit or surface interpretations of data items, whereas latent themes reflect deeper, more hidden meanings, assumptions, or ideologies (Boyatzis, 1998; Braun and Clarke, 2006). Semantic themes "…within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written." (Braun and Clarke, 2006, p.84). On the contrary, the latent level looks beyond what has been said and "…starts to identify or examine the underlying ideas, assumptions, and conceptualizations – and ideologies - that are theorized as shaping or informing the semantic content of the data" (Braun and Clarke, 2006, p.84).

Braun and Clarke (2006) establish a six-phase framework for conducting this type of analysis:

Step 1: Become familiar with the data,

Step 2: Generate initial codes,

Step 3: Search for themes

Step 4: Review themes,

Step 5: Define themes,

Step 6: Write-up.

To familiarize herself with the data, the researcher transcribed it and read and re-read the transcriptions. The MAXQDA Software was used to create initial codes in the second step. The researcher attempted to capture the client's experiences and opinions at this stage, and codes were created based on these observations. The researcher then looked for suitable themes and subthemes and collected codes under each of them. The prospective themes were then examined to see if they were applicable to the codes, and a thematic map was created. The fifth phase involved creating a clear explanation for each subject and naming them.

2.4. THE RESEARCHER'S PERSPECTIVE

I lost a very close friend of mine because of the Coronavirus and nowadays, I travel through this grief experience with my friend's family and I have witnessed their agony beside mine. Each of us experiences are very unique and reveals our own reality and narratives perspective about life, death, and the reborn cycle.

To me, we do not experience the world in the same way even if we are coping with the same phenomenon and there is no way to generalize human experiences. I feel responsible for my friend and his family and I want to dedicate this research to him, to honour his death and our memories of us. Thus, my personal story and my relationship with death might have an impact on the research process and on my results as well regarding my sensitivity and reflexivity.

As a therapist candidate, I think that deaths, especially beloved ones, are the best teachers to observe our unique relationship with life as well. For this reason, I believe it is valuable to conduct a qualitative research study to understand the grieving experiences after death and their relationship with life after such a painful experience. The therapist should observe how people get in touch with the world after this kind of challenging experience to honour the life, death, and reborn cycle with their clients.

The loss that I have experienced recently, and mentioning my grieving process in my own therapy process, carrying my pain to the session room for a long time let me to observe myself during the decision-making and writing stages of this research and to think about how the grieving process I went through affected this research. For me, as a therapist, sometimes I felt a bond with my client in terms of going through grieving together. While the client was talking about the difficulties of her grieving experience, I realized that some emotions were also revived within me and made me remember my own loss.

According to my observations, both my own therapy process and its relation to my grief, my therapist identity and my researcher side may have caused this study to find a harmony within itself. In many ways it was a difficult journey, grieving is a multi-layered experience, including common and unique features. From time to

time, I realized that my own emotions and experienced guided me, on the other hand I observed and focused on different aspects of grieving.

However, being aware of my sensitivity to this topic helped me to find balance during the research process. In many ways, this research has been a practice for me to observe boundaries me and my client, differentiate them and seek balance. I received a lot of support from my therapist and supervisions, especially at the points where my feelings were intense and compelling. This support made easier for me to move forward by differentiating processes and conducted this research. I reflected a lot on the grieving process I went through, and pondering on its connection to this research, if I had not experienced such a loss, this study might have been different.

I spent a lot of time with death as well as the intense and heavy emotions that death unleashed. Both in my own therapy process as a client and as a therapist, who witnessing to the client and holding space for her in the therapy room, I felt the sharp breath of death near to me. This situation radically changed the person who I am today, my perspective on life and death. As a result, I tried to protect my inner compass and seek both emotional and professional support through the research process, while I was conducting the therapies with my client, who went through a familiar process with me I seek balance at every stage of the research. I hope this research will be a gift to the strong unity of life and death.

CHAPTER 3: RESULTS

By using thematic analysis method explained previous section, four main themes were identified. These four themes were labelled "feeling the absence," "emotional responses to husband's death," "increased self-awareness," and "showing agency" Each main theme's subthemes are presented and described below (see Table 3.1).

Table 3.1.

Themes and Sub-Themes

Feeling the Absence of the Husband	Emotional Responses to the Husband's Death	Increased Self Awareness	Showing Agency
Remembering Hospital Stay and Feeling Desperate	Anger	Childhood Experience and Seek for Change	Emotional Resilience
Nightmares about the Husband's Death	Guilt	New Perspectives and Understanding	Thinking about re-establishing Relational Boundaries
Being a Single Mother	Overwhelmed	Self Appreciation and Positive Thinking	Mandatory s. Free Choice
Good Memories in the Past	Fear of Loss		

3.1. FEELING THE ABSENCE OF THE HUSBAND

Feeling the absence of the husband and the change in her and children life after the death were mostly expressed by the client during the selected therapy sessions. This theme addressed husband's involvement in client's life and leaving her with sense of loss after the death. The client mostly mentioned that how death changes her life. Depending on her, four sub-themes emerged: "remembering hospital stay and feeling desperate," "nightmares about the husband's death," "being a single mother," and "good memories in the past." While she mentioned she was desperate during the hospital stay, she also expressed her yearning for the good days with her husband.

3.1.1. Remembering Hospital Stay and Feeling Desperate

Especially in the first sessions, the client often talked about the difficulty of her husband's illness and how exhausting the hospital days had been for her. She mentioned that she struggled with every process on her own during her husband's hospitalization and that this situation had worn her out. She stated her anger that during her husband's hospitalization, she took care of both his husband's and her own family and made them explanations about the process, while at the same time dealing with the careless attitudes of the hospital staff.

"Of course, in the hospital too, when I took all the responsibility as I always do, I didn't say it's your son, come take care of it, I can't do it. You know, it's rare. Here, everyone was coming and staying for a few days, taking care of the children. Everyone goes home because it is a troubled place and no one wants to stay there. Because there are 3 small children, there is always something to be done. There is a sick man who needs to be taken care of. I don't know if they thought they were somehow getting it done anyway. I got just phone calls and didn't mean anything, and it's an extra burden to me, so tell them all the time, that's how it happened, the doctor came, he said, I'm talking about the hospital process. Yes, tell his brother, father and mother the same thing every time they called. I don't know if I would do

it now, so if they are very curious, I would say please come and look and take care of him. Also, I talk to the doctors, I talk to the nurses, I struggled on my own, it was really hard." (Session 8).

The client expressed her feelings of uneasiness, confusion, and her sense of responsibility on the first day at the hospital, make herself felt as a nightmare.

"So at that moment I was not alone, there was someone at home, we went down together, he was lying on the floor, and then the ambulance came, it seemed like a nightmare, when I think about it now, I was in such a thing that I didn't understand, something was going on around, we took it, so we put it in the ambulance and hospital we went. Afterwards, roentgens were shot, talking with the doctors, they said that he would be handicapped, I didn't know what would happen, I guessed only his father or somebody, his brothers were at the hospital and so on. I was constantly next to the doctors, I was the only one who run everywhere with my husband, nobody would stop me, nobody said to me 'my daughter, if you want to sit down, I'll go' I don't know, maybe I wouldn't let them go, I don't know what sense of responsibility I felt that I couldn't leave him alone when the doctor said something, I always went out and informed everybody who kept wait there. I don't know what could have happened, my husband's back was broken, his leg was broken …" (Session 8).

The client also talked about how shocking her husband's death for her related to hospitalization period. She talked about the shock, anger to the staff and immense pain she experienced while she was taking her husband to the morgue right after his death.

"My husband is dead and we would take him to the morgue. That night, I said something to one of my acquaintance few hours ago, 'Aunt A, I am very afraid of the morgue, I have never been to the morgue, you know' I said that and then, a few hours later I took my husband to the morgue. When we go down to the morgue, the nurse or some other stuff was with us, I was exhausted, so my husband was lying on the stretcher and I was taking him to the morgue. So now I can't imagine, I was all shocked at first. Then I realized that they laughed and talked about an everyday matter next to me... What was that? Was that all their humanity was over? It may

mean nothing to them, but I'm putting my life down to the morgue right now. I'm farewell to a piece of my soul, to my husband! So, I was in pain and all I want was just respect or is humanity dead? Okay, it doesn't mean anything to you, any person is dead and gone for you, okay, but not okay for me, respect me!" (Session 8).

When the client reflects on her hospital days in the therapy, she expresses how difficult days they were, how desperate she felt in those days, and her struggle, she put up on her own, genuinely shocked her.

"That's right, one does it if it has to be done at that moment. When I think about it now, it feels like I couldn't handle it, it doesn't feel like that at the moment, but I mean, you do what needs to be done. Time passes like this and now. I had to talk to the doctor, they humiliate me, but I run to get information again, there are many doctors with his nurse and assistant, there would be medicine to be taken and everything. Then, when I think about it now, I don't know what I went through, how difficult it was, but I say that, I don't feel that way at the moment, then now it's as if I couldn't handle it if I lived now, God forbid anyone else, but..." (Session 8).

3.1.2. Nightmares about the Husband's Death

The client mentioned that she experienced nightmares and intrusive memories, especially related to hospital stay. Also, she was expressing her sadness since she had nightmares all the time. Then, she continued to question why she mostly experienced negative dreams and this questioning increased her pain related to death of the husband.

"I am not well today, I saw my husband in my dream, it was 6:30 in the morning, I woke up, it was bad like that, I always saw the things like this, they were operating at the hospital, they were doing something, they were operating my husband without fainting him, I saw his wounds and so on, I was very impressed, of course, so I am very impressed now. troubles and such. It's like I think of it over and over again. Last night, I yelled at my eldest son and then he felt asleep crying because of his

guilt. While I was saying that I slept badly or something, I also dreamed under the influence of the conflict with my son..." (Session 8).

The nightmares excited difficult emotions of the client, they also implied unresolved anger and guilt of the client as observed in the therapy sessions. The client mentioned that she was not being able to get rid of the negative effects of the dreams for a few days after dreaming. Through the dreams and the nightmares, she acknowledged the loss after her husband and she reconsidered all the hospital process and the struggles she experienced.

"I usually have such bad dreams. I don't know why, it must have impressed me a lot. It was really hard times at that time, it was very difficult to feel that helplessness, that is sickness, that I couldn't do anything. I did try to do everything that I could, but to a certain extent, run after the doctors in the state hospital, run after the nurses. They're all behaving very badly. They didn't treat me humanly, I don't know maybe because of their workload." (Session 8).

In this sense, following bereavement the client has expressed distressed about specific aspects of her husband's treatment rather than the moment of death. Losing a loved one can be traumatic in any circumstance, but in this case losing someone to psychological disease involves a number of traumatic memories and experiences from hospitalization.

3.1.3. Being A Single Parent

The client stated that the death of a husband is a difficult and complicated experience not only for her but for an entire family. After the death, she continued her life with her three children and thus, she experienced being a single parent in many aspects.

"I feel so helpless, I have many things to take care of, all three are small for their age. You know, I have to help all three of them with their lessons. There are times when they cannot do it alone, and then they fall into despair, they cannot do it alone. Apart from that, chores await me. There are office-related, business-related things. Even if I work from home, I have responsibilities to do. I don't have time for myself,

I want to. You know, being able to sit calmly and watch something at work or do something or just sit, doing nothing, not talking at all, but most of the time this is not very possible. You know, I don't have a husband that I can tell you to help children with their homework and pick them up from school." (Session 1).

She mentioned that she tried compensating for her husband's part, so she got very tired and stressed not being able to be in two places at once. The client often talks about how tired she was and she bored with her routine. With the help of the therapy, she expressed her hope for changing the routine and create some free time for herself. Otherwise, she overwhelmed and got sudden burst of rage.

"I mean, it's hard to be at home most of the time, of course, there are times when I feel intolerant with children and want to be alone. They are young too, so my little boy can do things on his own, but I have to help him with his homework. There are times when I get bored and want to breathe, but this is not very possible either. While they were going to school, at least I could create free time such as meeting with a friend, having a coffee, and it felt good. Now we don't have such a chance, nobody can come home, I can't go. Therefore, there are times when I am intolerant, irritable and nervous. In this tension, it inevitably reflects on children, no matter how hard I try not to reflect it, so my voice gets louder, I don't know how to explain it. Sometimes I yell at them, then I regret like a vicious cycle … There are moments when I feel helpless and don't know what to do. I mean, it's hard, it's hard to be a single parent, it's hard to shoulder everything alone." (Session 1).

The client clearly expressed her yearning for husband and she was longing for the presence of him. She missed their daily routines, she missed presence and companionship of her husband. She experienced her husband's absence in parenting level, she wanted to talk about their children, make plans for future and share some romantic moments with her husband as well. The client experienced a loss in their interior being, she felt an absence in her emotional world. She expressed her yearning and loss both in past and future tense. She both remembered him including past memories and she was sorry for losing their future plans as well. She tried to contain both children's and her emotions after the death of the spouse.

"In other words, I am experiencing both my own loss and the loss of children. Inside of me... As I said before, children would be upset, depressed, I don't know, some difficult emotions they experienced. Also, I missed my husband very much and I missed having someone in my life and sharing something like this with him. I mean, we looked at something like that, I went to their village with my husband, my mother-in-law and my sister-in-law when I was pregnant with my eldest boy, I saw their village for the first time. My husband had taken many such videos in there. The way we joked with each other there, I don't know, pissing each other off, laughing, etc. It was so sad to see them after the death of him. As I said, I realized that besides missing husband as a person, I also missed experiencing those feelings with someone. So, I felt that I needed to experience something like that. It made me sad too. Sometimes being alone feels good, so I'm afraid someone will come into my life and do something wrong or making children upset. But sometimes this loneliness can be very heavy. Being alone is difficult and I miss sharing life with someone, sharing love, I don't know, talking and laughing about things in common, talking about children, laughing or chatting, whatever it is, I need it." (Session 24).

Parenting alone is one of the difficult experiences that the client felt the absence of her spouse the most. The absence of a partner to talk about children's issues upset the client, and it constituted an important part of her grief. In the absence of her husband, the client stated that a different kind of solidarity emerged with her nuclear family, especially with her sister. Since the client's children were still babies, when the husband died, their sharing stayed limited about the children in the past and the fact that they could not support each other in terms of parenting in the future which client grieved over a lot.

"Being single parent is exhausting. Not being able to share something with someone… Not even sharing an idea. Whether we do it this way or that way as it is discussed between the parents. I don't know much anyway; my children were very babies when I lost my husband… So, shall we just take them to the doctor? Here you got the food? Our conversations were like something like that… My eldest son was four and a half years old at that time, and I didn't live long… Now, as they

grow up, there are new and new things in me. I share all the routines and changes with my sister the most." (Session 1).

3.1.4. Good Memories in the Past

The client often mentioned that she tried to coping with the reminders of the husband, not only nightmares and desperate experience but also good and lovely memories. She faced with the loss of his husband since she began to remember the good days they experienced together. Anniversaries, dreams, children's special days evoke client's intense grief related emotions and she reminisced about the good old days.

"We had never watched the wedding CD before, so I thought we should watch it. Children said let's watch. Then we watched a little bit in the evening. So, I guess we couldn't watch much of it because it's a CD and it's old, but our conversations with my husband, the wedding part, they watched some scenes. Just like that, the CD was stopped when the jewelry ceremony started. Then the children left the living room, I saw the part my sister and my cousin on the wedding day. It was a little heavy, I guess, emotionally, I felt bad. On the other hand, being able to talk and share something about my husband more comfortably with the children like this gives me relief." (Session 24).

She pointed out that, she only remembered good memories for a long time. Then, client talked about her complicated feelings, sometimes she couldn't find the strength even to talk about the death and loss, and sometimes she found relief and meaning in all this experience.

"At the beginning, I only remembered the good times we had and it hurt me a lot at that time. Maybe it was a year, maybe it was a year after that period, I began to remember difficult times in such a way. In fact, when I told my sister, she said to me, I was waiting with curiosity when you would think about those difficult times. I was always telling good things about my husband. I'm talking about our good times, I never forget him. Difficult days didn't come to mind at first, I didn't think of hard days, always good times, good times, the good times we lived with the children, the

good times we lived together, the romantic times, I missed those days very much, they come to your mind... I said last time, and now the thought would be very difficult, if my husband was alive, maybe everything would be much more difficult for us right now. Children are growing up etc. so maybe it was good for us like this, but I don't know." (Session 8).

Remembering the good memories of the past and reviving the loss also brings about the losses related to the future. Dreams, hopes, plans for the future that they plan to do but cannot do. Thus, the client feels sorry not only for husband's loss but also all the losses related to her husband's death.

"Yes, so it's happening. I don't know if I feel sorry for myself too... I grieve for that loss, but when we lose someone, you also lose what you plan to live with. I don't know… I lose something about myself. Therefore, I guess it's a bit like feeling sad for myself. (Session 16)

3.2. EMOTIONAL RESPONSES TO THE HUSBAND'S DEATH

After the death of her husband, the client stated that she experienced many different emotions intensely, both with the effects of the memories of the past and the changes in her and children's life after the death. In this sense, she felt a range of emotions. However, some of those feelings took place more in the client's life, and she experienced some feelings more intensely. The client stated that she mostly felt angry in her daily life whereas she felt guilty about the past. Based on client's expressions, four sub-themes occurred as "anger", "guilt", "overwhelmed", "fear of loss".

3.2.1. Anger

One of the reasons the client started therapy was the desire to find a solution to the outbursts of anger that had recently started to increase. As the sessions began to open up space to the client's experiences of anger, it was noticed that the anger she felt had a strong connection with the experience of mourning. The client's anger

was often directed at the difficulty of being a single parent, the resentment and anger she felt towards the death of her husband, and sometimes towards her parents, especially his mother in connection with her childhood experience.

"So, it's about anger. So, of course, I don't experience very big explosions. The fact that my voice is getting louder and it gets louder is disturbing. Most of the time I try to control myself, but I realize the thing. In other words, I show my anger more easily when I know it in situations where I won't get much reaction from me. For example, I get easily anger with the children." (Session 4).

When the client's anger was deepened in therapy, many disappointments such as the change she experienced with bereavement, her return to her family's home even for a short time after her husband's death, and her loneliness, were revealed.

"I have cried a lot, why did you leave me? Why did I have to go back to my parents' house? I mean, there were times when I said that my husband left me and I was in trouble and got angry with him." (Session 8).

One of the reasons that reveal the anger of the client is that she has to take on parenting responsibilities alone after the death of her husband, such as getting the children to do their homework, doing daily routine that need to be done, and feeling angry with the fatigue caused by not being able to spare time for herself.

"Now I experience the same thing with children's homework. It's frustrating, of course. I mean, I'm so bored with my eldest boy and I can't stand the little ones this time. I got very angry last night, he is not my only child, I do not want to be stressed by his homework and reflect this on others." (Session 8).

The client brought her anger towards her mother to the sessions and said that she wanted to work on her anger towards her parents. Through this anger, intergenerational parenting styles and mother-child relationship were at the client's agenda and asked herself questions for change.

"I remember the fear I experienced after the death of my husband the other day. Because in my childhood, there was no one to protect me against him, but I do not want children to experience what I went through. I mean, let them not hear their shouts and calls for something like that, I'll pack them up and take them away so

they don't walk under my father's feet. Let him be comfortable, let me be comfortable, everyone be comfortable. So, I was relieved in the sense that I go out to another house. I mean, I'm experiencing that stress. When my father comes home angry, he may shout at the children, he may shout at me, but at least I did not allow him to shout at the children, I don't know." (Session 8).

3.2.2. Guilt

The client experience guilt intensely in different forms. She experienced guilt both in her daily life and in her dreams as well. While the client thinks that her husband was suffering, she felt guilty, then she was questioning whether she has enough support for her husband during the illness or he has received a good treatment or not.

"It feels like my husband was angry with me too. So, I don't know if we would go to a private hospital or… there are many regrets after death." (Session 8).

From time to time, the client questioned whether he was paying due attention to her husband's illness, or she said that she blamed herself for thinking that I had caused my husband's death and suffering.

"I was questioning that if it was different, I would have taken him to another hospital. If I did it like that, would it be different? A part of me still asks this question after 6 years... At the beginning it would have been much more, I was blaming myself a lot. I mean, it's like I'm guilty of everything that happened, that's what I said, I went too far, I caused a lot of stress, his disease has relapsed and went so bad because of me. It's like 3 children came because of me." (Session 8).

One of the issues that the client felt guilty about was the anger she experienced. After getting angry with the children, she felt intense guilt, and this guilt reminded the client of both her childhood and the death of her spouse.

"You know, at that moment I scream at work, I raise my voice, then I regret it. Because I shouted, this time I go and calm myself down and explain my problem to children again with a smoother, calmer tone and a calmer speech. You know, I wish I didn't get angry because I was very angry." (Session 4).

3.2.3. Feeling Overwhelmed

After husband's death, one of the most dominant emotions in the client's life is feeling overwhelmed, this state of being overwhelmed has increased with the pandemic period. With the pandemic period, the long quarantine period caused the client to enter a vicious circle with her 3 children, and feeling overwhelmed created by this cycle manifested itself with outbursts of anger.

"I mean, it's hard to be at home, of course, there are times when I feel intolerant with children and want to be alone. They are young too, so my little boy can do things on his own, but I have to help him with his homework. There are times when I get bored and want to breathe, but this is not very possible either. While going to school, at least I could create free time such as meeting with a friend, having a coffee, and it felt good. Now we don't have such a chance, nobody can come home, I can't go. Therefore, there are times when I am intolerant, overwhelmed, irritable and nervous." (Session 1).

The client tried to cope with her constant feeling overwhelmed, however she felt herself unable to cope. The long-term effect of so many turmoils in the client's mental and emotional lives often leads to a sense of being overwhelmed, out of control, desperate, and powerless. In addition to the client's own mourning process, the effort to explain the death of their father to children and to cover their feelings increases her feeling overwhelmed and helplessness.

"In other words, children miss their father so much, rightly, there are moments when I do not know what to do. Especially ... my youngest boy, he was 1.5 years old when he lost his father and of course he didn't understand his death much at that time. He just felt sorry for our sadness. When his brothers talked about the father, he also remembered and was sad. Lately, he needs more, misses, cries. I try to console myself somehow, sometimes we sit down and cry together. There are moments when I feel helpless and overwhelmed and don't know what to do." (Session 1).

The feeling overwhelmed that emerged and intensified with the death of her husband lead the client to question her own childhood, as well as the difficulties of

being a single parent, and cause her to evaluate her relationships with her own parents. Especially in the first sessions, the client felt an increasing sense of overwhelming, helplessness, and expressed that she could not find the strength emotionally to cope with the intense routine, such as the restriction of social life with the pandemic, staying at home with three children, supporting the children alone, following the daily chores, helping her root family in the shadow of her bereavement.

3.2.4. Fear of Loss

Another of the feelings that the client often experiences after the death of her spouse is the fear of loss. From time to time, the client expresses that she is increasingly worried about the future of her loved ones and is afraid of losing them. The issues that worry the client the most is that her children are in the risk group due to the genetic transmission of bipolar disease, and that the psychological difficulties experienced by her sister remind her of the difficult period her husband was going through, and her fear of loss triggered accordingly.

"Sometimes I feel helplessness, a great fear and sadness. It seems as if the result of the helplessness would be lost. You know, if I can't do something, it's like I'm going to lose my beloved ones. This is what I felt the most after my husband died. If I could do something more, maybe he wouldn't have died. I've thought this way a lot. Now that's why feeling helpless will always bring losses, as if my beloved ones will slip out of my hand. I feel the same thing with children, I mean when I'm helpless about something, it seems like something will happen to them." (Session 12).

As the therapy process progressed, she sought therapy support for her children and sister. She stated that if something negative happens to them, she will feel herself responsible for this situation and feel guilty. The fear that emerged as the guilt he felt was leading the client to the death of her husband and to the hospital process.

"That's why maybe when I see something similar with my husband, in a psychological sense, I make an effort to lose it. Especially when I see a problem in

children, I try to solve it immediately because I am afraid that if it progresses, it will become like my husband and I will not be able to do anything again and I will lose them too. And now my sister is the same way..." (Session 12).

When this fear she feels increased, she was struggling emotionally, her need to control her children's and sister's well-being increased and she found herself in a dead end. This situation caused the client to find herself in a vicious circle, as the client felt helpless, she was afraid, and as she was afraid, she felt even more helpless and overwhelmed.

"Yes, I mean, in a way, I'm also very afraid of going through similar things with my husband's death, as a matter of fact... Because sometimes it gets really bad and I sense my sister's desire to hurt herself. You know, there has never been an attempt but she does not want to live. I'm so scared then." (Session 12).

As the client talks about the fear she felt, it seems that many emotions are intertwined with the fear. Fear leads the client to the death of her husband, and at the same time aroused the feeling of guilt. In addition to guilt, the client remembered that she mostly coped with the difficulties of her husband's disease alone including the hospital process, which caused her to question her marriage, root family relationships and childhood experience in the therapy process. The shock and sadness she went through with her husband's death and the grieving process she experiences caused the client to take precautions for their loved ones and almost try to "save" them.

"You know, I try to do what I can when I do something that will disturb it, I blame myself incredibly when I do something... I don't know like shouting at children, not being able to take care of them that much. You know, I have such a thing as if I do these things, they will get worse, their psychology will get worse. After that, I keep turning in such an impasse... That's why I want my sister to start therapy process as soon as possible, maybe this make me feel I can do something for her. I mean, this will relax me." (Session 12).

3.3. INCREASED SELF AWARENESS

This theme explains the changes that the client feels along with the therapy process. At the beginning of the therapy, the client was in a place where she felt more helpless, desperate, and compelled considering her life. During the therapy process, the client began to gain ability to look at her actions, thoughts and emotions through introspection and reflection. She focused on what she experienced in the past, and then she connected her past experiences with her life choices, starts to believe in the possibility of change, and to search for ways to change, as the therapy process progressed. In the meantime, the client took steps to show self-compassion, to relate to the grief she experienced again and in a different way, and to have a more flexible perspective towards life and herself. Sub-themes of this theme are "childhood experience and seek for change", "new perspectives and understanding", "self-appreciation and positive thinking".

3.3.1. Childhood Experience and Seek for Change

When the client questions her childhood experiences, she begins to make sense of why she feels mostly obligated and desperate in her life, ponders on the guilt she experiences intensely, begin to seek for different parenting styles from her own parents did. Also, she began to name and re-experienced the emotional injuries of her childhood with the therapy process. As the client reflects on her past experiences, her belief and hope in change begins to increase.

"It's been 5 years since my husband died, but maybe there are emotional baggage that I've carried for forty years… I mean, looking at myself and telling you, here I realize that I was influenced by something my mother said and something my father did, when I think about it and talk about it. Therefore, I never want to do such a thing on children. To leave a bad memory for them, to do something that will affect badly them, that's why I try to do something different, I hope to do..." (Session 1).

The client said that her mother's capacity to cope with difficult emotions was not enough, that her mother was more depressed than she was, when she felt

bad as a child, and that she felt distressed and sometimes even guilty at such moments. Now, as a mother, she said that she tries to be as supportive and calm as possible in places where children are bored and difficult.

"I was an overweight kid; my mother would get very nervous when we went to buy clothes for me. Well, what do I know, now when I go to buy something for the children, I struggle until they get whatever they want. In order for children to get out of the shop in the happiest and satisfied way, I do my best both financially and emotionally. I'm making an effort, so as I said, because my mother was more depressed than me, maybe that's what's causing some of my emotions today, I don't know." (Session 32).

Talking about the childhood was a difficult experience for the client, and the dominant and intense emotion she felt about her childhood was mostly anger towards her parents, but as the process progressed, the client began to feel compassion towards both her childhood and her parents.

"My father was very furious and still he is. We were afraid to say anything to him. Now I am more comfortable with him… As I got older, he became calmer. As I got older, I became more confident, it was not possible for me to say anything to him. A father who always yelled and shouted us. Such authority does not allow anything. Now, I decided to be a different parent… I was hurt and saddened by this kind of parenting. Now I do not want to do the same to my children." (Session 24).

The emotional difficulties experienced by the client in the childhood and the hope of being a different parent cause the client to strengthen her bond with therapy and made her feel hopeful for change. Over time, her anger towards the parents began to turn into understanding and compassion as she empathized with the difficulty and uncertainty of being a parent. Thus, the client's perspective on herself and on life began to be flexible.

"I'm trying to be more understanding. I wonder what happened under the anger and he behaved like that? I guess I'm improving in this sense, just like I'm not just getting angry with my parents anymore. Now I understand that why my father was actually angry... He had a lot of burdens, I don't know, he was very afraid of losing what he had earned. I mean, he had a lot of stress on him. Well, maybe he couldn't

let us out, maybe he was taking his anger out on us, and of course, I understand him more and his love for us., I don't know, I can see that he was trying to protect us the way he knew and learned from his parents. The older I get, the more I understand him. I understood that there is no such thing as perfect parenting, I also learn motherhood thanks to my children, I develop and change with them. I try to find my way" (Session 16).

3.3.2. New Perspectives and Understanding

As the client began to observe her childhood, her past experiences, her intense and dominant feelings, and her life decisions throughout the therapy process, she began to look at the messages conveyed to her by the emotions, the needs and wishes underlying her emotions and decisions in a different perspective and she started to establish new meaning bonds.

"Well, maybe I wasn't aware of these emotions in the past, maybe I didn't realize it what I felt actually, but now I feel them, I mean, I was not so aware of the worthlessness I experience. Actually, I wasn't aware of it, before the therapy, now that I realize it in the therapy and make connections. It is sad to realize it as well." (Session 32).

Working through difficult emotions and making connections with the client's past experiences, caused the client to experience ambivalent emotions. While the feeling of worthlessness, hopelessness and helplessness forced the client emotionally, naming and giving meaning to those feelings helped the client to hope for change, to create different meanings, and to evaluate the past with a more flexible perspective.

"I really want to do it, I really want to be able to change, and I really admire people who can appreciate themselves. I am amazed how they can do it. Because my priority has always been someone else, and others have been my children, my family, my siblings. I wish I could do it for myself, but I haven't quite reached that stage yet. I'm just in the awareness stage, so it's hard." (Session 16).

As the therapy process progressed and the client began to notice some changes in her daily life, her belief in both therapy and change increased, and she felt more motivated for change.

"In a way that I will not give up, even if I feel I am at the beginning, maybe it will not be exactly in soon, but I will try to do something for change. I feel hopeful." (Session 32).

3.3.3. Self-Appreciation and Positive Thinking

The client, especially after the death of her spouse, started to appreciate her efforts to cope and continue, she started to look for ways of change and development, to appreciate her efforts in terms of struggle for life, to realize her strengths, rather than to compare herself and to feel inadequate, she looked at motherhood and parenthood from a different perspective, as a learning journey. Issues such as re-engagement with the increase of self-respect, sense of competence and worthiness, and the possibility of new relationship started to come to therapy to talk and think about.

"Both now and in the past... I am trying to do something by taking all kinds of responsibilities with 3 children alone. Of course, there are times when I made mistakes, for better or worse, but there are times when I think I'm doing well. So, we are used to each other now, children are getting older, life will get easier or harder, I don't know. What will we see, what will we do in the future? There are times when I find life is very difficult, yes, when I need a shoulder, when I need such an emotional support. But most of the time, we kept order, we go with the good and the bad, I say I am not bad, I mean, my self-trust is increasing." (Session 16).

The guilt she felt decreased and she started to appreciate her effort - to move away from her perfectionist and rigid thought patterns, and she began to look for ways to manage her parenting experience and relationships in a more balanced way.

"As a matter of fact, that new side of me is emerging. I mean, my self-appreciating side showed up. I accomplished something again, yes, I am succeeding with good

and bad, I mean, thank God my children are healthy, they are doing well in their classes, I don't know, I try to give proper upbringing as much as I can. I try to do my best for their health. Eating, drinking, vitamins etc. Anyway, it's like I'm trying to support them psychologically as much as possible." (Session 16).

She tried to develop her cognitive flexibility, she appreciated herself instead of blaming. So, this way of thinking opened the way for the client to feel more secure and hopeful for the future, as she began to evaluate the past from a different perspective.

3.4. SHOWING AGENCY

This theme includes that the client realizes her strengths, feels competent about her life decisions, establishes cause-effect links between the experiences she had in the past including her childhood. In addition, she interpreted her history from different perspectives rather than evaluating the past as only bad events, also she criticizes her root family's parenting style objectively and reasonably, thus she redefines the relational boundaries instead of blaming herself or others. As a result, she started to make new decisions in line with change. Sub-themes of this theme are "emotional resilience", "thinking about re-establishing relational boundaries", "mandatory vs. free choice."

3.4.1. Emotional Resilience

With the progress of the therapy process, the client began to look at the difficulties she experienced in the past from a more flexible point of view, to realize and express her inner strength with a non-judgemental mind, and to approach from a place where she was emotionally balanced and confident in herself and her resources in the face of the ups and downs of life in the future.

"I tell myself that I deserve better strongly. I mean, I went through very difficult experiences, I had difficult times. I mean, I'm in a place where many people ask how are you doing, how are you coping. There are times when it was very hard.

Habits, my children, my house, I take it somehow, there are times when it is much easier. Look, I'm doing it somehow, so I'm getting over it. I mean, I can cope with the difficulties of life, I say that you deserve, you deserve better, and I feel this deep down of myself." (Session 16).

As the client became aware of her internal and external resources, her self-belief has increased, she expanded her awareness of her emotions, and she realized the realities she could not control, her self-blame for the past and her husband's death gave way to acceptance.

"After losing my husband, I blamed myself a lot... So, I found something to blame myself for in his death. When I look at it now, I say that you did your best, you did everything that needed to be done under those conditions." (Session 16).

The client began to have a perspective that was more flexible, open to development and change, and began to stretch her perfectionist side, rather than having rigid and worrying thought patterns. Thus, she began to move on with life.

"I mean, life is not something I'd call it completely over, it's something that's been going on and it's constantly changing. As children grow up, their needs change, their personalities change. I try to adapt to them as well. So, I can't fit something, but I can't put it in something perfect. I see I am changing through the therapy as well." (Session 24).

3.4.2. Thinking About Re-Establishing Relational Boundaries

Since the first sessions, one of the issues that the client complains about and wants to change most frequently is to rearrange the intertwined borders within the family, to say no easily, and to create spaces for herself to breathe.

"I also have the inability to say no, so it's not easy for me, so I take on responsibilities that I can't handle, then I struggle under them, I can do it or not, I can do it as much as I can, but I can't say no. Now it's different, you know, it was not possible for me to say no to my father or something beforehand. Now I can do a little better, I can do it now, I can say" (Session 4).

One of the reasons for the client to worry about setting boundaries is that she continues to be a single parent after her spouse's death, and that there may be a few other adults in her life with whom her children can bond with and be close to. After the death of her husband, the biggest supporter of the client was her sister, and the client stated that she had difficulty in setting boundaries, especially with her sister, that this situation angered her from time to time, and that she needed to rearrange her relational boundaries with her sister.

"I'm afraid of hurting my sister. Because she is not stable psychologically. Well, you know, she continues her therapy, she is still very fragile and very obsessed. So, I'm afraid of causing something bad. However, on the other hand, it makes me angry, I express my anger in some way or I explode. I'm looking for another way to express my anger." (Session 12).

As the client's self-compassion, self-confidence, self-esteem increased and self-blame began to decrease, the themes of reorganizing relational boundaries began to come to the sessions more. She sought a new way of relating with others from a system that she forgot herself, pushed her limits and postponed her needs.

"Not too long ago, my priority has always been someone else, and others have been my children, my family, my siblings. I was also very surprised when someone does differently. I have a hard time understanding how people can do it. Then I say that I change it, so that's what I should do. I wish I could do it myself, but I haven't quite reached that stage yet. I'm just in the awareness stage, so it's hard..." (Session 32).

3.4.3. Mandatory vs. Free Choice

At the beginning, client felt quite overwhelmed by a narrative in which she normalized the difficult life events that she experienced. She felt powerless, unable to cope, and had to put up with what was going on. Over time, she shifted to a perspective where she felt competent to deal with her experiences, taking on the agency, seeing the positive and solution-oriented aspects.

"The judger in me was very dominant before, but now I felt more powerful, I began to see the things I accomplished." (Session 16).

As the client strengthened her emotion regulation skills during the process, her belief and expectation of change that could occur with the therapy process increased, and she began to feel more hopeful.

"I mean, I haven't found yet how that new method of living exactly is, but I will find out. At least I am aware that what I can change things, I will change, I hope." (Session 32).

In addition to the increase in the client's self-confidence, it seems that her trust to world and her belief in activating the channels she can get support from when it is necessary.

"Yes, I mean, I can do and cope with difficulties, or at least I can reach people who are much more competent than me and support me. In other words, if there is a problem, I have confidence that they will notice it much quicker than I do, which gives some relief. I realize the change in myself because I see that change after I started therapy." (Session 12).

3.4.4. Change in Individual and Relational Measures

For the client, presenting problem was leaving the past behind and getting through the grieving process. To determine positive and negative results I used the criteria for each measure and if changes moved the client into a different category (e.g., clinical designation to non-clinical designation, mild to moderate symptoms).

In terms of positive change, client's depression and anxiety moved from moderate to mild. When both scales are evaluated together, it was considered that during the therapy, therapist focused on reflecting on and normalizing client's thoughts and emotions especially her anger, understanding intergenerational patterns by working on her genogram and reframing behaviours in terms of relationship with her parents and attachment needs including empathetic listening and validation. Also, therapy provide her a place in which she expressed her pain related to bereavement clearly. It was thought that the handling of this situation in therapy might have been reflected in the scales.

Figure 3.1.

Depression Scale

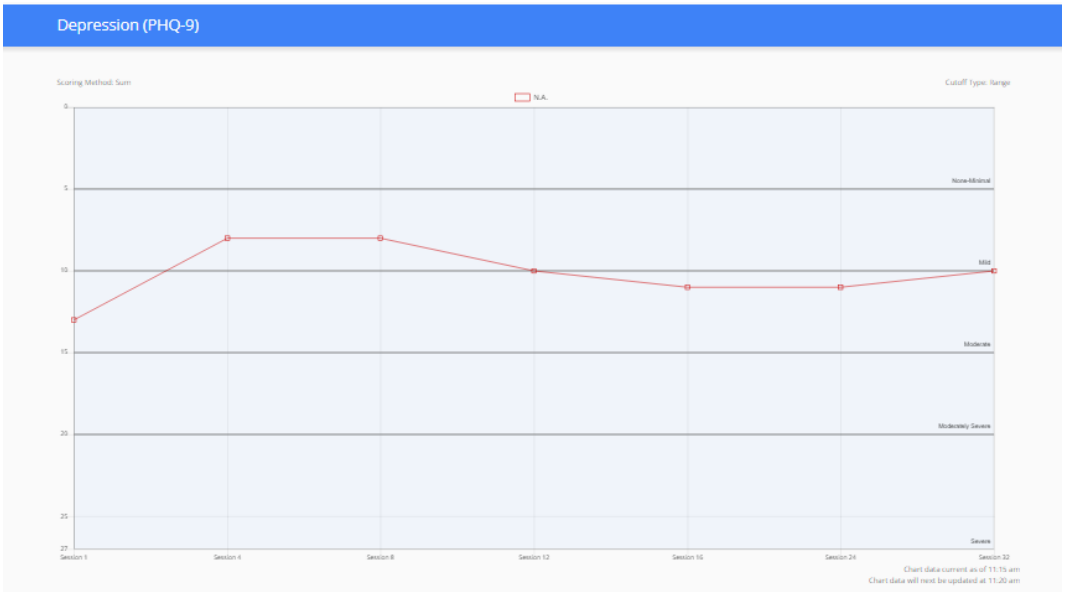


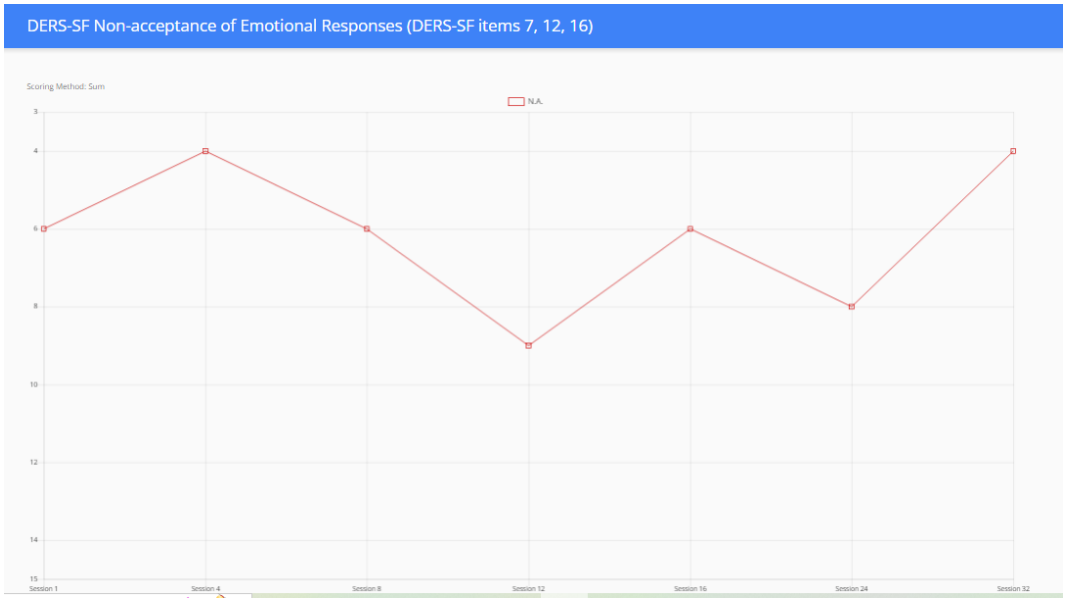
Figure 3.2.

Anxiety (GAD 7)

Also, Sub-scales DERS Non-Acceptance of Emotional Responses and Limited Access to Emotion Regulation Strategies scores decreased between the sessions 1 to 24. During the therapy, the client strengthened her capability of containing and regulating her difficult intense emotions and she would be aware of her coping strategies as well.

Figure 3.3.

DERS- SF Non-acceptance of Emotional Responses

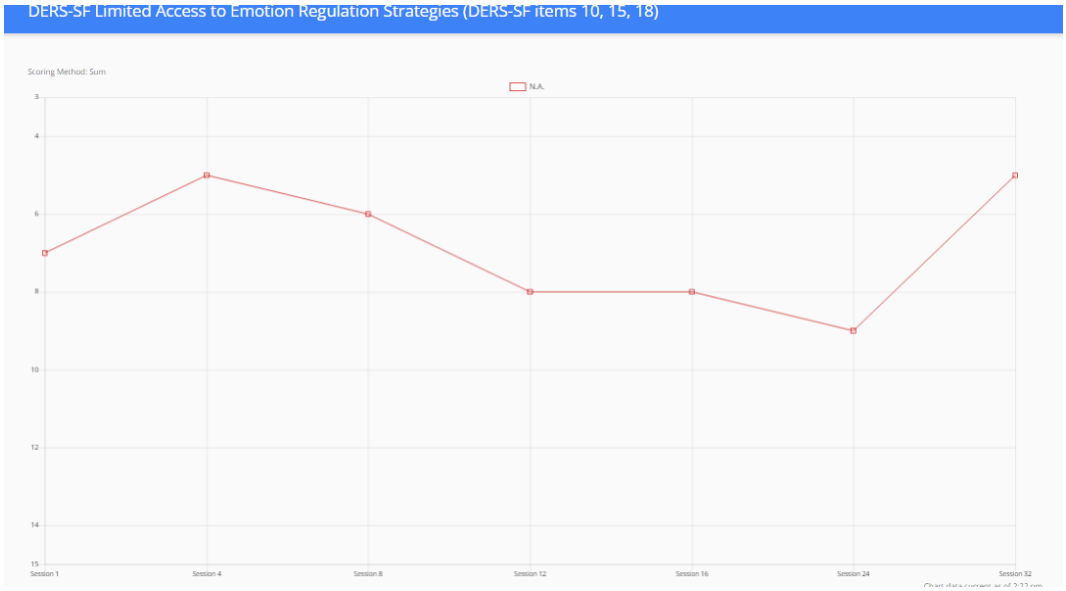


In terms of negative change, her difficulty in recognizing, naming and expressing emotions became meaningful when it was associated with the client's family history.

No major change was observed in the DERS (Difficulty Emotion Regulation Scale),

Figure 3.4.

DERS-SF Limited Access to Emotion Regulation Strategies



The fact that the client's attachment needs were not met in the relationship she experienced with her parents, along with the history of abuse she experienced at the age of 7 and the attachment wound and the difficulties in her marriage and loss of her husband afterwards, caused her to position herself as a "victim" in her close relationships. However, the score increased from 6 to 15 in the Attachment-Avoidance Sub-Scale. This rise is interpreted as follows; the client shared that she chooses being distance in close relationships to protect herself emotionally, in the sessions this need and sensitivity was worked through, client’s need to establish a relationship was interpreted through relational perspective, the of distance was associated with not being able to express herself clearly, and the fear of saying no because of the underlying thoughts were she was unloved and worthless. The relationship established in therapy made the client realize the need to withdraw herself a and her fears, so may have been reflected in the scales in this way.

Figure 3.5.

Attachment-Avoidance

The client frequently stated that she will have difficulty working with feelings of guilt and regret and related memories during the sessions. DERS Scores show the difficulty experienced by the client in coping with emotions. Since it was difficult for the client to deal with those difficult feelings and life experiences in therapy and to start talking about the bereavement, the therapist had tended to continue the sessions at the speed of the client and as much as she wanted to share.

Figure 3.6.

DERS- Lack of Emotional Clarity

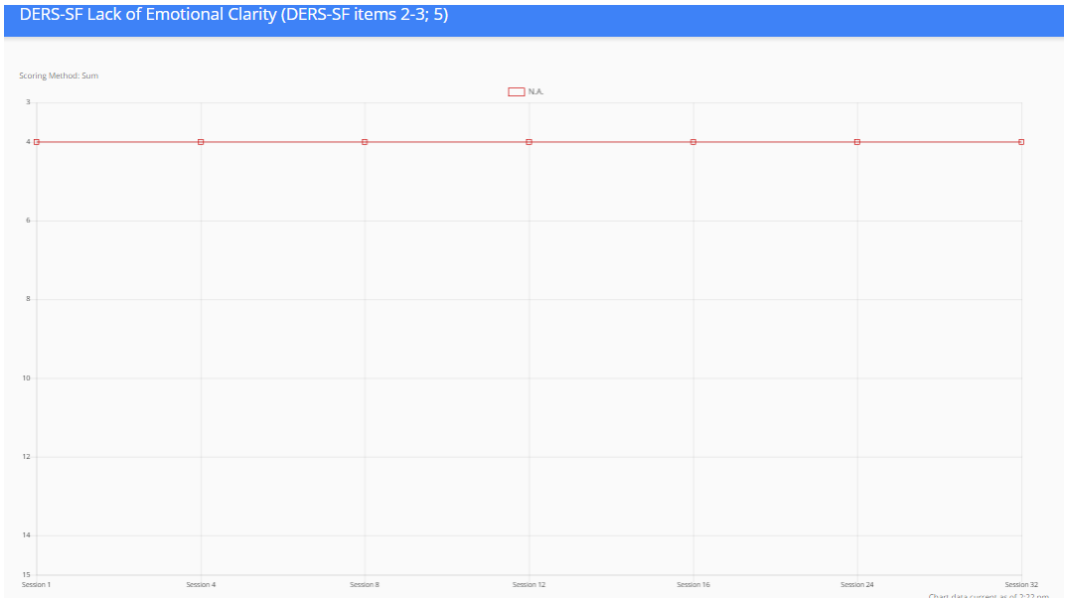
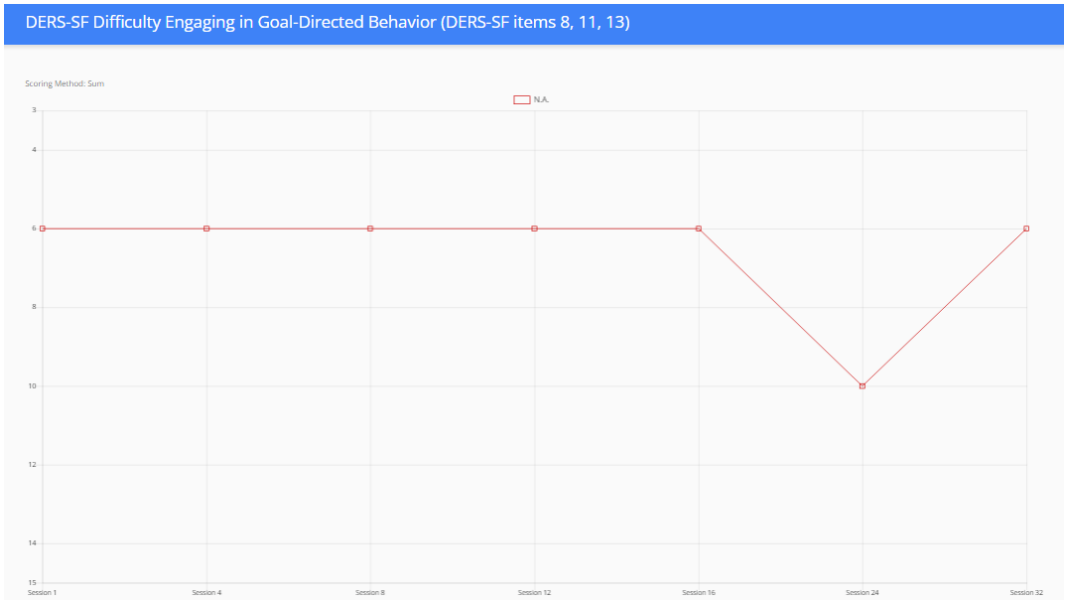


Figure 3.7.

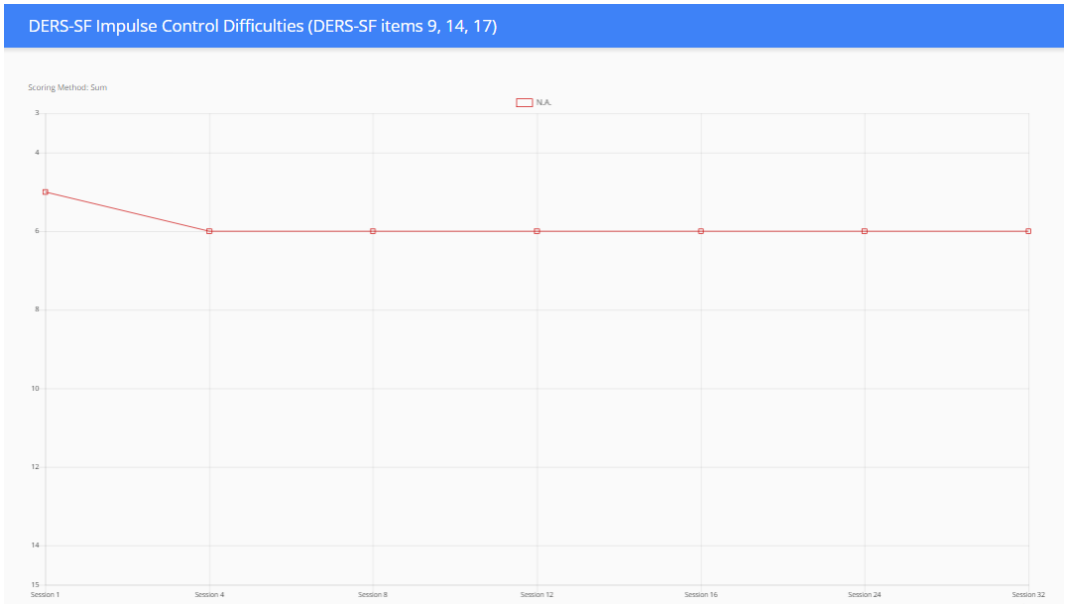
DERS-SF Difficulty Engaging in Goal-Directed Behavior



One of the primary goals of therapy was to make the client experience therapy is safe place to share as much as she was ready. Establishing secure based relationship was very important with this client who had traumatic experiences of neglect, abuse and loss.

Figure 3.8.

DERS- SF Impulse Control Difficulties



CHAPTER 4: DISCUSSION

The aim of the study was to investigate significant themes in the systemic therapy process with a grieving individual, and to explore client's individual and relational symptoms change over time during systemic therapy. Client's grieving experience, her complaints, emotions, thoughts and expectations have been explored during the systemic therapy process. Four major themes in the present study were identified from the selected sessions: 1) feeling the absence of the husband, 2) emotional responses to husband's death, 3) increased self-awareness, 4) showing agency.

Feeling the absence of the husband theme was included three sub-themes, remembering hospital stay and feeling desperate, nightmares about the husband's death, being a single mother, good memories in the past. The sub-themes that emerged in this theme represented the void that the client feels after the death of her spouse, the visibility of her spouse's absence, the difficulty of the hospital stay, and her longing for the good days they lived. The second theme emotional responses to husband's death comprised four sub-themes: anger, guilt, feeling overwhelmed and fear of loss. These sub-themes concentrated on the intense and dominant emotions of the client after the loss of her husband in terms of her past, present and future reflections and expectations. With the progression of the therapy, client mentioned her evolving mindset, her new perceptions and thoughts about her past experiences by means of her increased self-appreciation. Rather than only focusing of negative sides of the past, she began to work through her experiences comprehensively. Thus, childhood experience and seek for change, new perspectives and understanding, self-appreciation and positive thinking are sub-themes that client pointed out her change process, discussed under the third theme increased self-awareness. Finally, showing agency theme referred to client's changing coping strategies, her capability to influence her functioning, taking responsibility for her actions and choices, attending on adjustment to her relational boundaries and seeking for the ways of saying no. Subthemes fall under the theme

of showing agency are emotional resilience, thinking about re-establishing relational boundaries, mandatory vs. free choice.

In this chapter, the four main themes will be discussed in relation to literature. Clinical implications will be mentioned based on the current study and the previous findings on this subject. Also, limitations and suggestions for future research will be discussed.

4.1. DISCUSSION OF THE THEMES

In the beginning of the therapy, the main theme brought by the client to the session was the feeling the loss of her husband's death, and the following difficulties and experiences associated with that loss. Due to the unusual circumstances related to the pandemic, she stayed at home with her three children during the quarantine period. As a result of psychological impact of quarantine period the client was passing through a phase in which she re-examined the changes that occurred in her life after the death of her husband whereas she felt overwhelmed and experienced bursts of anger, and then her husband's death re-emerged in her psyche with intense emotional responses. At the initial stage, where the therapeutic relationship is established and basic information about the client's life is gathered in detail, the client brought up both the difficult hospital process she went through before her husband's death and the mourning process she went through after her husband's death; The foundations of the therapeutic process were laid, in which the emotions related to grief are revived and began to work through in therapy, and the loss of the grief brought on by the death of the spouse and the losses triggered by the pandemic process are worked in depth in the therapeutic work with the bereavement. Consistent with this, grieving from a constructivist perspective, is the process of rebuilding a world of meaning that has been shattered by loss. Neimeyer et al (2009) mention that bereavement may be the one nearly universal stressor for humans, and data shows that for a significant proportion of people, the pain that comes with it can feel like a life sentence. The struggle to meaningfully integrate the loss into the survivor's life narrative, in a way that establishes a thread of

consistency and importance in the middle of a chaotic transition, is brought into clear focus when viewed through a constructivist lens. Similarly, in the present study, grieving experience, struggle to integrate the husband's loss client's life and the emotional responses to the husband's death have also been stated. The client was trying to make sense of her husband's death including the difficulties of the illness process, the struggle she had during his hospitalization, and the death that followed. Similar to the point that the structuralist perspective, especially emphasizes one of the main searches of the client when talking about the grief experience was to grasp the "meaning" of what is happening in her own psychology, and integrate the experience of loss through finding time and place in her own mind and lifeline.

The psychological process of integrating the loss experience was manifested itself through dreams, remembering the challenging and nostalgic memories, and the client was talking about them in the therapy sessions. As Klass, Silverman, and Nickman (1996) suggest; after death, relationships with the deceased do not necessarily have to be severed, and there is a potentially constructive function for preserving continuous bonds with the departed. This concept indicates an acceptance that death ends a life, not necessarily a relationship. Rather than 'saying goodbye' or seeking closure, the deceased may be both present and absent (2014). In this research, the client was trying to make sense of the illness and loss process whereas she tried to establish a new kind of relationship with her deceased spouse with dreams and nightmares as well.

Since Worden (2008) put forward "Task-Based Model", grieving should be viewed as an active process involving four tasks: (1) accepting the reality of the loss; (2) processing the pain of grief; (3) adjusting to a world without the deceased (including both internal, external, and spiritual adjustments); and (4) finding an enduring connection with the deceased in the midst of a new life. Consistent with this model for the client her partner's death was most visible for the client when she experiences emotional difficulties of parenting after the death of her husband. Especially with the quarantine period, when social life and the contact with the outside world were restricted and most of the time has been spent at home for a long

time, the client tried to take on many different roles such as adapting children to online lessons, supporting them in homework, covering their emotional needs besides their need of academic support, as well as her personal challenges. It has been observed that the client's efforts to balance her own affairs have been very difficult, and she tried to cope with the emotions that are quite intense from time to time and that she has difficulty in getting distance with those emotional responses ending with burst of rage. This process shows parallels with the task-based model (2008), where the client started to engage with the loss again and adjusting the world without her husband.

The loss, which manifested itself especially in the field of parenting, caused the client to face intense emotional experiences, along with the loss of the lover with whom the client was in romantic relationships and emotional closeness, she also lost the one with whom she could talked about children and accompanied themselves in life. She longing for her husband whereas she directed anger and guilt at herself. As many previous researches show that, mourning is a highly individual process with universal features. From this point of view, this study has taken the psychological paths of a grieving client in systemic therapy as a research question and aimed to examine whether there are emerging patterns together with the changes in therapy with a grieving individual. The first theme that emerged in this study shows that at the beginning of the therapy the client’s grieving experience focused on the feeling the absence of her husband, along with the intense emotional burdens related to the spouse's illness and death, and also showed the connection between the single parenting process and the grief. Since previous studies in the literature show that grief is a comprehensive emotional experience that involved many emotions. In the current study, second theme includes sub-themes related to the dominant and intense emotions experienced by the client after the death of her spouse.

Another main point that client mentioned is her emotional responses related to her grieving. Thompson and Neimeyer (2014) underline that grieving is a process that refers to the psychological aspects of bereavement or the feelings triggered by a profound loss, particularly the suffering experienced when a loved one passes

away. Accordingly, grieving is a complicated phenomenon since the process includes both common and subjective reactions in terms of emotions, feelings, thoughts, and practices. Thus, anger is the most intense emotion that the client feels, which affects her daily life negatively, and which she cannot make sense of it and often regrets getting angry to the children. In the therapy, anger was processed in a relational context from a systemic perspective, and it revealed that anger is connected to the grief that comes with the death of the spouse's associated with the difficulties of single parenting. Also, client's anger is connected with resentments related to past experiences including parenting style that was experienced by the client, and its influence on further generations, besides conflicts in their relationship with their own parents. Since systemic therapy focuses on individual and the inner world in the creation of systems theory and practice, therapeutic process worked through systemic perspective and paid attention to the generational transmission.

After anger, the second main feeling that the client experiences the most and has difficulty to deal with is feeling guilty. Her spouse had trouble with bipolar disorder, hence the client mostly struggled and support him alone during the hospital stay until husband's death. Then, the nightmares of the client were full of self-blaming, thoughts that her dead spouse is angry with her and beliefs that she did not try hard to heal him enough, so those feelings put her in a deep depression. However, when guilt is handled with a systemic lens, both the client's almost "rescue" effort and the need to "be perfect" and "control everything" become meaningful when her childhood experiences and her relationship with her family are taken into account. Consistent with previous research have mostly focused on what therapists do to facilitate therapeutic change, while little is known about the client's experience of treatment (Kuehl et al., 1990). Enactments, paradoxical directives, reframes, externalizing inquiries, response modes, and other systemic work interventions and strategies have prompted increased attention (Heatherington et al., 2005). In this study, along with the new relationship established in therapy, the guilt felt by the client began to evolve and change with the progression of the therapy process through reframing and connections established with past experiences and the new relationship established with the therapist.

In this study, another sub-theme emerging is that the feeling overwhelmed. The client mentioned her intolerance and felt psychologically trapped in the beginning of the therapy; after death of her spouse she felt desperate, the loss of control and, hopelessness. Also, she felt alone with these feelings and she faced a state of suffocation. In the therapy process, it has been observed that dealing with this crisis together with relational and systemic work, working in-depth through reflections and reframing, also re-establishing a relationship with her spouse within her internal system decreased her feeling of guilt. According to Bonanno's research, before their spouse's death, those who had the most distress tended to have high degrees of personal dependency. Dependency was a major predictor of grief reactions in people who were not depressed before the loss. Consistent with that, the client who has dependency patterns came from her early childhood experiences, mentioned her depressed phase after her spouse's death, even she felt depressed in the beginning of the therapy. Bonnano et al.'s findings suggest that participants who had improved depression appeared to be relatively maladjusted and self-absorbed, with insufficient coping mechanisms to deal with their stress. They were relatively negative and ambivalent about their marriages, were more likely to have a seriously ill spouse, had the lowest levels of instrumental support, were highly introspective and emotionally unstable, and strongly believed that the world was especially unjust to them (2002). In this study, the client who improved depression after death has a similar pattern as Bonnano's research suggested. The death of the client's spouse as a result of suicide caused by bipolar disorder attack also shaped the mourning process that the client goes through. Especially in the early stages of the therapy process she had sensitivity with mental health of her children and sister, and if she observed any clues that panicked her, she sought therapy for them in order not to experience a similar process with her husband. It has been observed that the client's need for control increases at this stage, the fear of loss recurs, and she tried to protect herself from a "possible" guilt. Her need for control and sensitivity for her closed one's mental health worked through in the therapy by establishing connections with the grief process that the client goes through before. This study shows that in addition to the loss of a loved one, the period before the

loss, the reason of death of the loved one and the responsibility undertaken by the client in the hospital stay influenced the intensity of the emotions experienced during the bereavement process, the risk of improving depression and the strategies to cope with the bereavement.

With the progress of the therapy process, the containing of intense emotions and grief experience by establishing connections with the client's childhood experiences promotes the client's hope for change. Also, her perfectionist and rigid thought patterns began to evolve into a more flexible, positive and balanced perspective. Dourdouma et al.'s (2019) research findings suggest that clients' agency is critical to the therapeutic change process and illustrate that clients' motivation and personal work in therapy is important. Thus, as the client began to realize the contribution of her effort and motivation in the therapy process to the change. Her negative future expectations have changed, her intense feelings of guilt were relieved, and she began appreciating her own effort. Thus, she felt her functioning in terms of taking decisions for her life rather than complaining her "bad fate". Literature on grief focuses on the concept of resilience in recent years. Killian (2016) emphasizes the importance of social support and he emphasizes on resilience as an important alternative to the dominant discourse of trauma. In this study, similar to the literature the client began to develop an alternative story to loss experiences accompanied by heavy and difficult emotions, her courage to get in touch with mourning, and her relationship with life began to change with the systemic interpretations. Becvar (2003) promotes that family therapists who provide treatment to persons who are dying or grieving make a significant commitment to their clients and that in order to be genuinely effective, they must also be included in that commitment and include themselves in it. Research shows that in particular, that the therapist's self makes a difference (there is an importance placed on who s/he is rather than what s/he does) and that his or her emotional capabilities, along with his or her knowledge and techniques, are described by participants as essential for therapeutic change (Dourdouma et al., 2019). In this study, the researcher was also going through the grief experience may have been

one of the triggers of the change by making space for the client to focus more on the grief experience, to work in-depth and to talk.

Hall emphasizes that there is a movement to continue bonds with the deceased one rather than say goodbye and let go. As Klass, Silverman, and Nickman (1996) suggest, after death, relationships with the deceased do not necessarily have to be severed, and there is a potentially constructive function for preserving continuous bonds with the departed. This concept indicates an acceptance that death ends a life, not necessarily a relationship. Rather than 'saying goodbye' or seeking closure, the deceased may be both present and absent (2014). As the client's feelings of guilt decreased during the therapy process, she began to form a new relationship with her deceased spouse. Previously, she was hesitant to talk about the death of her husband and to answer the children's questions about their father. Then she stepped into the experience of "living with grief", she looked at the old photographs of her husband with children. In time, she talked about her husband with children and the death of husband ceased to be an "inconvenient" topic and became a part of their family stories. Hereby as the client started to have conversations with children that she thought she would not have courage to do that, she started to feel more hopeful for the future by making the death of her husband a part of her lifeline, and as her capacity to stay and contain difficult feelings developed, she began to feel more hopeful and secure for the future.

Dual Process Model (Stroebe and Shut, 2007) suggests that the griever engages in emotion-focused coping in the 'loss orientation,' investigating and expressing the variety of emotional responses related to the loss. At other times, the griever engages in problem-focused coping and is required to focus on the many external adjustments required by the loss, such as diversion from it and attention to ongoing life demands, in the ‘restoration orientation.' When the 4th theme is considered together with its sub-themes, the change was observed most in terms of client's relationship with life which refers to containment the death of her spouse, her childhood experiences, positive projections and expectations to the future different from the beginning of the therapy process. The client rewrote her story in which loss was dominant and she felt almost responsible for the death of her

husband and felt guilty. She changed her way of engaging with loss she had experienced in which she began to see and strengthen her coping strategies and resilience. As the literature supports, the client started a therapeutic work focused on coping and continuing bonds with her husband's loss, thus she was activating her internal and external resources, as she started to open up space for the experience of grief in therapy.

As the client's relationship with the grief experience began to shift from an inclusive and flexible perspective, her questionings about her current relationships began to come into the therapy process. The main theme that the client wanted to change in her close relationships and sought a new balance was related to relational boundaries. She started to question of her position to take emotional responsibility of others, delaying or ignoring her own needs, straining her resources, being unable to say no and feeling guilty when she said no, and reconsidering the boundaries of relationships with a perspective that she takes care of herself and takes into account her internal and external resources, her needs and emotions. Hereby, the client will be able to take the initiative, make choices, take responsibility for her choices, feel flexible changing her decisions rather than accepting herself as helpless, powerless, desperate, stuck and guilty in the face of negative experiences and difficult life events and her sense of agency was developed.

For many years, the emphasis was focused on the "external mind," on observable interpersonal connections; nevertheless, in recent years, systemic therapists have started paying overdue attention to the "interior mind." The therapist's and client's inner and outer worlds, as well as their relationships with the social structures in which they are embedded, have all become terrain to be explored (Boscolo&Bertrando, 1996). In this study, circular questions which are one of the systemic therapy techniques, and relational interpretations refers to internal and external relations revealed by circular questions, began to change the client's perspective about the difficulties she experienced through dealing with them in a circular and relational ground. Thus, she realized her effect on the change in herself and her relations which means her sense of agency was developed.

The client valued the relationship with the therapist and she was open the therapist inviting her to have open communication, expressing her emotions and listening in a non-critical and empathic way. This finding seems in line with the Common Factors literature that underlines the therapeutic alliance as the most important factor in leading to change in therapy (Sprenkle, Davis, & Lebow, 1999). Common factors that are specific to family therapy are conceptualizing difficulties in relational terms, expanding the treatment system, and expanding the therapeutic alliance. As the therapist established a strong alliance with the client, she was able to encourage the client to be more vulnerable in the sessions and access their primary emotions.

Another important therapeutic moment that the client mentioned her childhood trauma beside her husband's death. From the Emotional Focused Therapy with Individual the core practices of the EFIT (Brubacher, 2019) are empathic attunement, following the attachment model and validation. After these core steps the client attuned deeply to her non-verbal experiences and getting aware of her internal and interpersonal cycles which constitutes change in the therapy.

It is also important to note that, the client was going through the pandemic and the restrictions such as full-time quarantine and sessions have been conducted online. It might be affecting her anxiety and depression level as an external factor.

4.2. CLINICAL IMPLICATIONS

Grief is one of the most common human experience, the findings of this study can be an example of understanding grief through systemic perspective. Firstly, this study shows that grief is an experience including various emotional responses, especially is characterized with overwhelming pain. Especially for the clients who have early developmental trauma and chaotic family experience, may have to cope with the losses caused by neglect and abuse of early childhood besides the current loss. Therefore, systemic interventions such as validating and reflecting emotions and reframing are very important during the process of establishing therapeutic alliance. In addition, being researcher and the therapist at the same time,

and the client is a significant addition from a systems perspective. The therapist involves the patient in her own development by using ongoing evaluations through the PRN MFT platform and analyzing the process and the change in sessions through thematic analysis. Also, this study shows that working with clients with traumatic background, including her husband's traumatic death by suicide for this study; slowing down the therapy process with bringing the client's experience to the present moment, rather than deepening intense feelings of loss experiences, and also to emphasize the strengths of the client and to strengthen internal and external resources gain importance. On the other hand, it is preferable to give client time and space, as well as to identify triggering points where clinicians can intervene to provide space for safe self-expression in terms of intense emotions.

After building therapeutic alliance and creating structured safe place, the process of change began to show up. The change occurred as a result of many different components. This study shows that providing a safe place for the client, make her express difficult emotions gradually and so she began to consider on her early experiences, her relationship with her nuclear family patterns and question the intergenerational patterns through systemic perspective.

For the clinicians, self-reflection is important to distinguish between personal dynamics and client's experience and emotions. Also, recognizing how therapist's own dynamics influence therapeutic process and progress is critical to stay, regulate and contain intense emotional experiences of the client. Since grief is highly intense emotional process, therapist's self-care gains more importance while working with grieving clients. Besides self-care, grief can cause emotional, physical and bodily tiredness and pain, so therapists may open a space for somatic exercises such as grounding, focusing and regulating breath, pendulation and so on to connect with the present moment and get ahead with vortex of intense emotions by getting relax [See Somatic Experiencing International (SEI) and European Association for Somatic Experiencing (EASE)].

Finally, grief is unique to person who experience it as well as its common, universal and cultural components. Thus, this study can be utilized working with bereaved parents and family systems or can lead group therapies in the light of

revealed themes of this study which aim to work with bereaved parents after spouse's death. Support groups or programmes can help people to strengthen their external relations and social support as well as internal resources through *sharing* intense emotions, in a group experience, in a larger system.

4.3. LIMITATIONS AND SUGGESTIONS FOR FURTHER RESEARCH

The aim of this study was to observe process and change in psychotherapy sessions with a grieving individual through systemic perspective and interventions. There were several limitations in the methodology used and the results analysis. One limitation stem from the study's nature as a single-case study. Because I was the only clinician and researcher, the findings only reflect my therapeutic approach and also my personal sensitivity as a grieving individual. Therefore, it would be interesting to see how the therapy process and progress would differ if the therapy was based on a different therapy approach. As an alternative, a comparison study conducted by various therapists or based on various therapeutic approaches would add another layer to the discussion in future research.

Thematic analysis was used for analysing the session transcripts and I was the only coder and the therapist of the process as well. For further research, second coder can be involved to enhance the trustworthiness of the study. Because of my personal dynamics, I may have been biased toward them. It is critical to be aware of this bias in qualitative research and to interpret the results accordingly. In terms of session selection, I preferred sessions that are connected PRN system. This could have affected the study's trustworthiness. Since grieving is a highly individual experience along with common and cultural features, further investigation should be done with a broader sample to discuss individual's grieving experience with its common, cultural and unique features in Turkey. Also, "Being a Single Parent" can be discussed in gender perspective as "Being a Single Mother" in Turkey. Moreover, client change interview can be conducted in order to understand client's experience and perspective on her own therapy process and its significant components for change.

CONCLUSION

This study aimed to understand systemic therapy process and change with grieving individual. There were certain commonalities with the previous research client, as well as her unique grief related experiences. At the beginning of the process, the client mostly focused on her desperateness, hopelessness and her depressive mood and she expressed that she could not find an outlet in this vicious cycle. With systemic perspective, she changed her views on her past and she hoped for future with the sense of agency through her negativity diminished along with her anxiety and depressive mood.

These results are encouraging, since its systemic focus on grieving individual who tries to bring up three children in current Turkish society. Based on this research, group therapies can help people to strengthen their external resources and social connections as well as internal ones through sharing intense emotions which are hard to cope and contain alone in a larger system for further clinical research.

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APPENDICES

APPENDIX A: Consent Forms

İstanbul Bilgi Üniversitesi

Psikolojik Danışmanlık Merkezi

BİLGİLENDİRME VE TEDAVİ ONAY FORMU

Bireysel Terapi

Bu yazıyla danışmanlık/terapi süreciyle ilgili size bilgi vermek ve karşılıklı hak ve sorumluluklarımızı bildirmek istemekteyiz. PDM'den hizmet almayı kabul ediyorsanız (1) bu formu pdm@bilgi.edu.tr adresine e-posta olarak göndermeniz ve e-postaya "**Ekte gönderdiğim Bilgilendirme ve Tedavi Onay Formunu okudum ve formda belirtilen hak ve sorumlulukları göz önünde bulundurarak PDM'den psikoterapi hizmeti almayı kabul ediyorum**" yazmanız; veya (2) formun her sayfasını imzalamanız gerekmektedir.

- İçinde bulunduğumuz pandemi koşulları gereği, Danışmanlık Merkezi görüşmeleri yüz yüze veya "Skype" veya "Zoom" uygulamaları üzerinden gerçekleşecektir. Programların masaüstü ve mobil versiyonları mevcuttur. Görüşmeyi yapma ihtimaliniz olan cihazlara bu programları önceden kurmuş ve denemiş olmanız önerilmektedir. Görüşmelere yüz yüze katılacaksanız maske kullanmanız ve ulaşımınız sırasında gerekli sağlık önlemlerini almış olmanız gerekmektedir.
- Psikoterapi sizi merkezimize getiren sorunları dile getirme, anlama ve üstünde çalışma sürecidir. Standart bir görüşmenin süresi 50 dakikadır. Bu süreçten en iyi şekilde faydalanabilmeniz için görüşmelerinize tam randevu saatinde ve düzenli olarak katılmanız beklenmektedir.
- Görüşmeye katılamayacağınız durumlarda, 24 saat önce randevunuzu iptal etmeniz beklenir. 24 saat içinde yapılan iptallerde ve habersiz gelmeme durumlarında aybaşında alınmış olan görüşme ücreti bir sonraki aya devretmez veya geri ödenmez.
- 24 saat önceden haber vermeksizin katılmadığınız arka arkaya iki görüşme sonrasında terapi süreci sonlandırılır, bu durumda devam etmek istediğinizde Psikolojik Danışmanlık Merkezi'ne yeniden başvurmanız gerekmektedir.
- Çevrimiçi seanslarda, çalışmanın bölünmemesi ve gizliliğin korunabilmesi için sessiz ve sizi bir başkasının duyamayacağı özel bir ortam kurabilmeniz; eğer seansa

bilgisayarınız ile katılıyorsanız telefonunuzu uzak bir mesafede sessiz konumda tutmanız ve evde başkaları yaşıyorsa bu kişilerin seans sırasında bulunduğunuz odaya girmemesi veya sizi dinlememesi için gerekli önlemleri almanız büyük önem taşımaktadır. Gizliliği koruyabilmek için mümkünse bir kulaklık takmanız yararlı olur.

- Görüşmelerde konuşulanlar sizinle terapistiniz arasında kalır. Ancak kendinize ya da bir başkasına zarar vermeniz söz konusu olduğunda sizinle ilgili bilgiler terapistiniz tarafından, sizin de onayınız alınarak gerekli kişilerle paylaşılır.
- Kendi bakımını yapamayacak ve kendini koruyamayacak çocuk, yaşlı, hasta, engelli ya da hayvanlara şiddet/ihmal ve istismar söz konusu olduğunda gerekli kurumlara bildirim yapma yükümlülüğümüz vardır.
- Terapistiniz, mesleki konsültasyon amacıyla, kimliğinizi saklı tutarak bilgilerinizi Psikolojik Danışmanlık Merkezindeki süpervizörleri ve meslektaşlarıyla paylaşabilir.
- Seanslarda hiçbir şekilde görüntülü ve sesli kayıt **almamanız** gerekmektedir, terapistiniz de sizin **onayınız olmadan kayıt alınmayacaktır**
- Gerektiğinde, ilaç desteği konusunda terapistiniz bir psikiyatrla görüşmenizi önerebilir. Merkezimizde yarı zamanlı bir psikiyatr bulunmaktadır. PDM'nin hizmet alanının ya da çalışma koşullarının dışında kalan yardım ihtiyaçları için süreciniz sonlandırılarak güvenilir ve uygun ücretli kaynaklarına yönlendirme yapılacaktır.
- Aylık görüşme ücreti, ayın ilk veya en geç ikinci görüşmesinin sonunda aylık görüşme sayısı üzerinden hesaplanarak önceden ödenir:
    - **Yüz yüze Süreçlerde**: Aylık görüşme ücreti, TC kimlik numaranızla sizin adınıza İstanbul Bilgi Üniversitesi banka hesabına bağış olarak yatırılır ve bağış makbuzu ve faturanız danışmanınız tarafından size teslim edilir.
    - **Çevrimiçi Süreçlerde**: Aylık görüşme ücreti size bildirilen banka hesabına not kısmına "PDM Danışmanlık Ücreti" yazılarak sizin tarafınızdan yatırılır.
- **Kayıt İzni**:

  Seansların kayda almasına izin verdiğiniz takdirde bu kayıtlar sadece eğitim doğrultusunda kullanılacak, bu kayıtların kullanımında kişisel bilgileriniz saklanarak gizliliğiniz korunacaktır. Aynı zamanda bu izni verdikten sonra istediğiniz zaman fikrinizi değiştirebilir ve izninizi geri çekerek kayıtların silinmesini talep edebilirsiniz. Kayda izin vermeniz veya vermemeniz kesinlikle size sunulan terapi servislerinin kalitesini etkilemeyecektir. Kayıtlar terapi sürecinin sonlanmasıyla birlikte silinecektir.

Bu izni vererek, kayıtlar üzerindeki tüm hak ve ilgilerimi Psikolojik Danışmanlık Merkezine devredersiniz.

Bu formda belirtilen kurallar çerçevesinde terapi sürecimde yapılan görüşmelerin sesli kayıt altına alınmasını: ☐ Kabul ediyorum ☐ Kabul etmiyorum

1. **Acil bir durumda aranabilecek kişi ve tel**:
2. **Acil bir durumda aranabilecek kişi ve tel**:

Ad-Soyad:

TC Kimlik No:

Tarih:

BİLGİ ÜNİVERSİTESİ KLİNİK PSİKOLOJİ YÜKSEK LİSANS BÖLÜMÜ

Bitirme Tezi- Bilgilendirilmiş Onam Formu
Sistemik Terapi Vaka Analizi

Değerli katılımcı,

Bu araştırma, Bilgi Üniversitesi Klinik Psikoloji Çift ve Aile Terapileri Yüksek Lisans Programı bünyesinde bitirme tezi olarak, Dr. Yudum Söylemez danışmanlığında Psk. Nilhan Algan tarafından yürütülmektedir. Araştırmanın amacı, bireysel terapi sürecinde yas deneyiminin ve terapideki değişimin sistemik perspektif bakış açısıyla incelenmesidir. Bu form Bilgi Üniversitesi Psikolojik Danışmanlık Merkezi Prosedürleri gereği onaylamış ve imzalamış olduğunuz Tedavi Onay Formu, Araştırma İzin Formu ve Kayıt İzin Formu'na ek olarak düzenlenmiştir. Bu form siz araştırmaya davet edilen katılımcımıza daha detaylı bilgi vermek amacıyla hazırlanmıştır. Lütfen tüm bilgileri detaylı bir şekilde okuyunuz. Açık olmayan herhangi bir bölüm ya da aklınıza takılan herhangi bir soru olduğunda araştırmayı yürüten kişiden daha detaylı bilgi talep edebilirsiniz.

Gönüllülük

Araştırmaya onay vermeden önce araştırmanın neden ve nasıl yapılacağını anlamanız çok önemlidir. Araştırmaya katılımda gönüllülüğünüz esastır. Araştırma hakkında bilgi aldıktan sonra onay vermeyi reddedebilirsiniz. Araştırma onayını reddetmeniz durumunda, terapi süreciniz üzerinde olumsuz bir etkisi olmayacaktır.

Prosedür/Gizlilik/ Araştırma sonuçlarına ne olacak?

Bir seneyi aşkın süren terapi seanslarımız yüksek lisans tez konusu ve amacı kapsamında değerlendirmeye alınacaktır. Tutulan kayıtlara sadece araştırmayı yapan kişi ve danışmanı tarafından ulaşılabilecektir, 3. Şahıs ve kurumlarla asla paylaşılmayacaktır. Araştırmada sizin adınız yerine takma isimler kullanılacak ve tüm kimlik bilgileri gizli tutulacaktır. Sizinle ilgili tanımlayıcı bilgiler de (meslek, çalıştığınız kurum, eğitim yeri vb.) yazım aşamasında gizliliği korumak amacıyla saklı tutulacak ya da değiştirilecektir. Araştırma sonuçları çalışılması planlanan tez kapsamında değerlendirilecek ve bilimsel makale ve/veya konferansta yayınlanması durumunda tüm kimlik bilgileri gizli tutulacaktır.

Araştırmamıza katıldığınız için teşekkür ederiz.

Adı Soyadı

Tarih

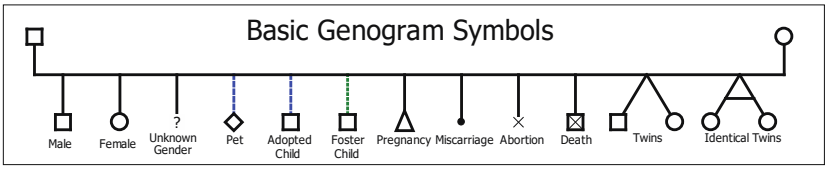
Lütfen onayladığınız kutucuklara işaret koyun

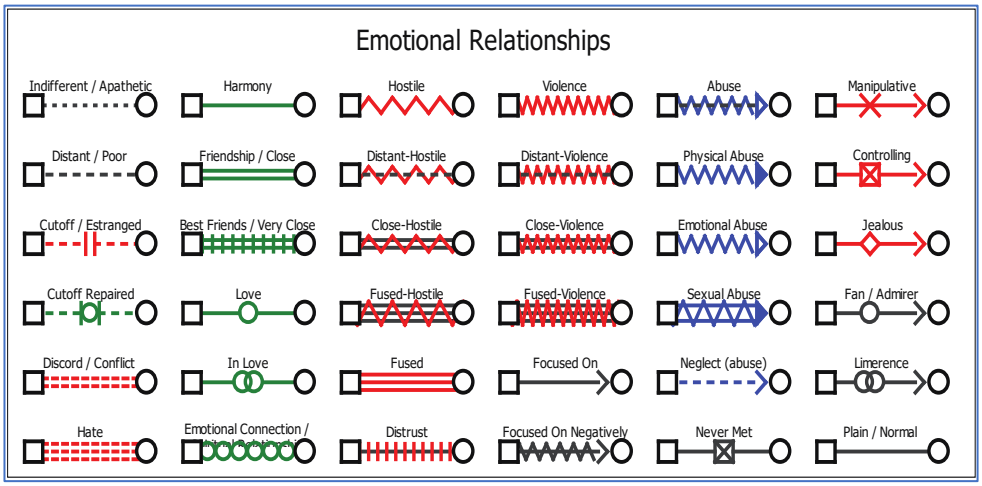
PRN sisteminde doldurduğum ölçeklerin tez için kullanımına onay veriyorum. ☐

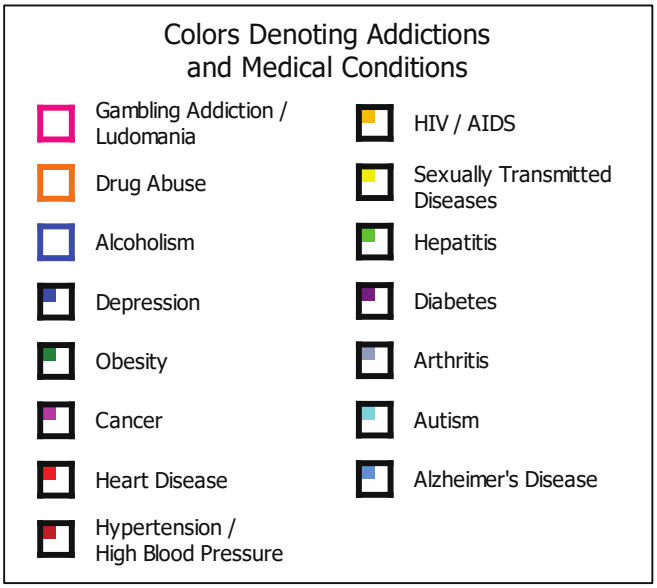
Seanslarda alınan görüntülü ya da sesli kayıtların tez kapsamında kullanımına onay veriyorum. ☐

APPENDIX B: Genogram Symbols

*Genogram symbols were retrieved from https://genopro.com/genogram/symbols/ .







APPENDIX C: ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.