Leila Jagodics-Varga

Caring for the Caregivers. Psychological Support for the Relatives of Patients

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1. Introduction

If we hear about someone getting injured, diagnosed with a disease, or having an accident, we typically wish that nothing similar happens to us or our loved ones. However, when the reality of an accident or disease is up close and personal, what used to be so easily distanced from ourselves becomes undeniably real. We can feel in our gut and whole body that something is wrong. The feelings of confusion, despair, denial of reality, and hopefulness appear at the same time. Psychologists who work at a hospital meet people (not only patients but patients' relatives) with affective states similar to those described above, among others, during the treatment process after an injury. An illness or injury is always the illness of the relatives and immediate acquaintances of the affected as well (although not in a physical but in an emotional way), considering that the illness also appears in their life as a new phenomenon. It becomes a part of their life and may even override their normal routine and habits.

In the present chapter, I wish to introduce the clinical side of health psychology with an emphasis on some aspects of the psychological care of relatives and close acquaintances. Although the patient is in the focus of psychological care, the patients' relatives also play an important role in the prognosis of treatment and recovery.

The patients and the medical staff work in cooperation to manage the illness according to the modern approach (Pilling, 2008). Relatives can also be involved in this cooperation and may provide key information to the medical staff apart from visiting and being available for the patient. From the view of modern medicine, the presence of the relatives by the patients are now fundamental in medical practice: family-centric medical care has become the standard (Jolley & Shields, 2009).

Working as a health psychologist involves contacting the relatives of the patients. In the perinatal or neonatal intensive care units, relatives are the main target group of psychological interventions. Whichever the clinical ward, the presence or absence of relatives and their impact on the patient are to be considered during psychological care. This is because patients are part of a social network that is defined by the disease. Moreover, attitudes toward the disease may modulate the manner of social functioning within this network. Thus, patients should be examined as part of the social network

that surrounds them. Knowledge of systemic theory and interventions serves as a fundamental background in the health psychological work with family members. By now, there is extensive literature on patient–relative relationship processes. For instance, it has been shown that the dysfunctional functioning of the family members contributes to developing and maintaining a disease, and the characteristics of relationship dynamics have previously been defined (Minuchin et al., 1975; Túry, 2000).

Family functioning and dynamics provoked by the new life situation vary from one family to another. The new functioning may not necessarily be a pathological one; however, changes in the previous equilibrium unavoidably leads to changes in the social network. Changes begin with the hospital treatment, but getting discharged poses another challenge to relatives and the entire family system. The presence of a disease affects the family members financially, physically, mentally, and psychologically. The loss of income, cost of treatments, and taking physical care of the diseased person place another burden on family members, who often are already under a considerable weight (Goldberg & Salloway Rickler, 2011). Family members' anxiety about their role, changes in social life, negative changes in emotional state, previous losses, and fear of unpredictable future losses also contribute significantly to their physical and mental deterioration (Askari et al., 2013; Carlozzi et al., 2015).

The main principle in health psychological work is to steer the above-mentioned psychological processes in a direction that supports well-being the most. The flow of psychological support is determined by the individual and the actual situation. Thus, the work with a client is always unique and personalized. A client can be anyone who attends psychological counseling: either a person undergoing hospital treatment/healthcare service or their relatives.

Psychological care in a hospital setting has the characteristic feature of not always being initiated voluntarily, driven by internal motivation. Furthermore, the traditional therapeutic frames regarding dual relationships cannot be maintained in all situations. Diversions from these therapeutic frames involve the location (e.g., counseling by the bedside), circumstances (e.g., patients in severe pain), undisturbed process (e.g., the presence of others in the room), as well as the time and time frame of the counseling (e.g., the duration of counseling cannot be precisely predicted). Additionally, secret-keeping cannot be secured in all circumstances. Working with the patients' relatives shares the same uncertainties; although, it is easier to establish therapeutic frames with them.

Providing support to relatives may occur on several levels in a clinical setting. The determination of family involvement is based on the model of Doherty (Doherty, 1995 in Hawley & Dahl, 2000), which I adapted to clinical work.

Minimal connection is when the relatives know about the psychologist, but there is no direct contact between them. Regardless, the attitude towards one another (e.g., expectations, presuppositions, and fantasies) still influences the psychological process

through the patient. The next level of connection is when there is an introduction or even a few sentences exchanged. This act is able to modify the preexisting fantasies and generates new ones at the same time.

On the next level, the client already shares some personal content and connects to the psychologist who has started an intervention. A common situation that also poses a professional dilemma is when the relatives react to the presence of the psychologist by sharing their personal struggles, while the psychologist is committed to a therapeutic process with the patient in that situation.

The level of involvement is the same as in the previous example when the relatives approach the psychologist aiming to gain information regarding the current state of the patient or to understand the psychological effects and treatment opportunities. This primarily requires psychoeducation which is usually terminated after a few sessions.

The closest connection is established with those relatives who ask for help in a voluntary and motivated manner in solving their problems and alleviating their difficulties. In this case, therapeutic goals other than psychoeducation may be set, and more of the psychologist's methods may be utilized. Securing the therapeutic frames is the most feasible on this level since the sessions are easier to schedule.

Supportive connections that are the amalgam of the latter two levels may also be realized in a hospital setting. This connection generally occurs with patients with a critical or severe condition or who are bedridden. In these cases, the connection between the psychologist and relatives develops spontaneously rather than planned, often by the bedside or during visitation, and is most commonly initiated by the psychologist. The encounters may include one or a few more sessions; however, these are usually connected to an emotionally loaded situation (e.g., a change in condition of the patient). Deeper psychological content generally appears spontaneously as a result of the situation.

The psychological work in these cases primarily has a supportive nature or involves crisis intervention. If the patient's condition worsens, the talk with the relatives has focus on the change-related emotions, whereas we conduct crisis intervention if the relatives just received the news of an accident or death. Nearing the patient's death or when saying goodbye to a passed relative, the aim is to support saying goodbye and improve the psychological and physical state associated with the experience of loss. Additionally, supporting the maintenance of a fundamental physical condition, such as bringing the relative a glass of water or encouraging them to eat or go outside for fresh air, may also be the task of the professional.

It is clear that health psychologists have a wide variety of clients with a great variety of problems and can encounter truly special and unique circumstances. From this wide range, I wish to elaborate more on the psychological work with grieving relatives in this chapter since grief processing forms an integral part of the counseling process in the case I will present.

2. Brief Introduction of the Grief Recovery Method

As shown in the above-presented examples, caring for people who have experienced or are experiencing a loss is an inevitable part of the helping profession. Thus, it is of importance for professionals to have sufficient knowledge of grief. The Grief Recovery Method (Friedman & James, 2011) offers valuable knowledge. It covers how to guide attitudes towards grief and what factors to consider during counseling apart from gaining personal experience. The basis of this technique is an action program for moving beyond any kind of loss. Once mastered, this method can aid the processing of loss for a lifetime. The method was developed in the United States by John W. James and Russell Friedman, who were motivated by their own grief to create an effective tool for themselves. They later used the method to also help others. The approach has been organized into a transcontinental network, bringing the opportunity of help to millions of people in many countries. Specialists trained in Grief Recovery Method are those who attend people during the processing of grief and teach them the steps of the action program using the Grief Recovery Handbook. An important aspect of working together involves the establishment of connectivity, reciprocity and a safe holding environment (Friedman & James, 2011)

3. Case Report Involving the Grief Recovery Method

The case presented below is of a client who approached me as a relative searching for help to process grief after a sudden loss. Interestingly, I had not met the client herself before, while the patient was at the intensive care unit, even though I met some of the relatives. A psychologist colleague referred the lady to me. I will name her Dalma in the case report. When she contacted me on the phone, Dalma mentioned that she had developed panic attack-like symptoms since the death of a relative.

During the first in-person encounter, I met a young lady in her twenties who wore dark but not entirely black clothes. She appeared neat and well-groomed. Her short and trendy hairstyle, and her accessories were indicative of a youthful, lively, and colorful personality. Her determined upright posture and searching gaze suggested that although she was anxious, she tried to overcome her anxiety and to show strength and firmness to the outside world. During the phone call, I pointed out to Dalma that the counseling is held within the intensive care unit. I always shared this information with the relatives who came for counseling, because the two consultation rooms I used as a psychologist to receive my clients were the same rooms in which doctors informed the relatives (and in which the relatives usually received the bad news). Therefore, I took into account the fact that the location where the relatives receive the bad news has a special meaning and is often loaded with anxiety and painful memories for the grieving person.

We walked to the consultation room together with Dalma after introducing ourselves. She followed me after a big sigh, gathering the strength to enter the room. I offered her a seat at the beginning of the conversation. She looked around in the small room and decided to sit on a different place from where she had been sitting when the doctor had informed her. Right at the start of the consultation, I asked her how it felt to be sitting in that room. In response, she recalled the occasion when she was there listening to the doctor, at first hopeful and then devastated by the bad news. Dalma reported that it is not in the intensive care unit but the room of the deceased relative where her anxiety is the worse. She then shared with me the details of the event which I only read in the medical history.

Dalma was the future daughter-in-law of a patient, called Krisztina, treated in the intensive care unit. Krisztina lived in a family house with her older son and his partner (i.e., Dalma) along with her other son of grade school age from her second marriage. They also had two dogs. Krisztina and her smaller son slept in one room, while Dalma and her partner slept in the other. However, they mainly used the common spaces in their daily lives, so they met and talked regularly. Dalma described her relationship with her future mother-in-law as strong and trusting: *"she was like a friend and sometimes more like a mother to me."*

Dalma could not recall any occasion when Krisztina complained of any physical symptom before the night she got sick. On the contrary, she looked excited because of an upcoming joyous event. During the night, the little boy noticed that her mother who was asleep on the other bed *"was breathing strangely"* and when he could not wake her, he alerted his brother and Dalma. They called an ambulance after another unsuccessful attempt to wake Krisztina up. While the older brother was checking the state of Krisztina with the help of the dispatcher until the ambulance arrived, Dalma calmed the younger brother down. The ambulance arrived fast and began the resuscitation. Dalma was simultaneously focusing on the state of the little boy, the restless dogs, and the events surrounding Krisztina. The memories of the resuscitation attempts, the instructions, and the insertion of the breathing tube burned into Dalma's memory. *"If I close my eyes, I see the whole scene in front of me. If I go into that room, I have flashbacks of the events. So I don't go into that room unless it's necessary."*

Krisztina was resuscitated and then brought to the hospital. Medical examinations revealed that she had suffered a heart attack in her sleep and that the oxygen deprivation caused significant brain damage. She was admitted to the intensive care unit in an unconscious state and received mechanical ventilation, as well as considerable pharmacological treatment. Although she was brought to the hospital due to a heart attack, her heart recovered as a result of the treatment. The brain damage due to the heart attack was so severe that it could not be resolved despite all medical efforts. The patient eventually got to a near-brain-death state. This was followed by the diagnosis of *"brain damage incompatible with life"* a few days later.

Family members and close friends were visiting Krisztina constantly throughout that time. The recovery of her heart gave some hope to the relatives. They were talking optimistically to the unconscious Krisztina, whom they described as a *"real fighter."* One of the relatives commented on her initially: *"If someone can recover from such a condition, it will be her."* However, it soon became clear that the brain damage was irreversible, and being hopeful turned into anticipatory grief displaying all characteristics according to the book. Some family members began accepting the probability of Krisztina's death, while others expressed their pain over the loss in the form of anger. They were looking for causes and someone to blame. They turned their anger against the medical staff. Some relatives started searching for alternative treatment options despite what the doctors said. I made direct contact with Krisztina's sibling, older son, and two close friends; however, I did not meet Dalma at the time. The acceptance of Krisztina's nearing death was aided by the spiritual belief and supportive attitude of the family.

From Dalma's story, I learned that another loss was associated with Krisztina's death. The younger child moved to live with his father and his father's new family. It was initially a temporary solution; however, with Krisztina's death, it became permanent. Dalma contacted me a few weeks later but prior to the memorial service.

She reported intense anxiety and panic attack-like symptoms since the night of Krisztina's heart attack. These symptoms appeared any time during the day but mainly occurred in the evening. Being alone made her feel anxious. Whenever she could, she sought company, either in person or by phone. She admitted that there had hardly been a day when she had spent even an hour alone. During the days when she was at work, she was more easily distracted (she worked in retail). Her partner worked in changing shifts, so he sometimes returned home in the late hours of the evening. On these days, someone stayed home with Dalma or his partner requested changes in his shifts so he could come home earlier. In her anxious state, Dalma experienced compulsive thoughts: *"Something's going to happen to me too," "What if I have an attack as well?"* Her partner was a comfort for her, but she still could not sleep at night for more than a few hours due to her anxious thoughts. It must be mentioned with respect to the medical history of Dalma that she underwent heart surgery as an adolescent. Due to the procedure, she regularly took medication which maintained her heart in good condition. Nevertheless, the death of Krisztina accelerated her anxiousness about her own health status. This resulted in a more severe panic attack, after which she visited the medical on-call service, and later she made an appointment with her family doctor to consult on her current medication status. On the other hand, Dalma emphasized that she did not want to take as much medication as she had after the surgery. She considered it a success that (even though she had had a major surgery) her condition rapidly improved with the adequate medication and her responsible attitude. Her experience was that the surgery did not hinder her almost at all in her everyday life.

She also felt anxious about what would happen on the memorial service in her heightened emotional state: *"How can I get through it?"*

Dalma also shared with me during the first session that she had lost her father a few years earlier. Although she had not maintained regular contact with her father after her parents' divorce, she reestablished a stronger bond with him when she was a young adult. Dalma was devastated by the death of her father, but in her opinion, his prolonged illness had prepared her to say goodbye. The suddenness of Krisztina's death, on the contrary, was *"a bolt from the blue or even worse."*

Dalma contacted me, determined to understand what had happened to her and overcome her anxiety. *"I want to get my old self back." "I have to face my fears."* This set a base for our work together.

3.1. Psychological Considerations

Initially, the two of us were sitting in that small consultation room with the shared knowledge of what happened at the intensive care unit, which developed a kind of connection between us. Then, as Dalma gradually allowed her personal experiences of the events to surface, her personal losses revealed themselves more and more to me as well. It involved the tragedy of suddenly losing what had been stable relationships, as well as the deep and trusting bond with her future mother-in-law, who gave her emotional support at the same time.

I find it important to always highlight for the relatives that they should only share with me as much as they are comfortable with at the moment. It is important to avoid the clients feeling compelled, tasked, or required to share the events when they are healing from grief and trauma. Of course, from a psychological counseling perspective, asking questions that go deeper is inevitable. Still, I consider it important to give the clients space to decide how much they wish to share from their traumatic events. After all, clients know the best what they can handle at the given moment. My responsibility as a professional is to create an environment in which the clients feel safe to open up and believe that I can hold the painful burdens they sometimes struggle to shoulder. Trust is not complete by the first encounter; it develops as a result of the professionals' empathetic feedback and resonance with the emotional state and story of the client throughout our work together. Therefore, we need to take into account that clients might knowingly omit some details or do not let the session go below a certain depth. This decision must be respected even if it somewhat hinders the understanding for us.

It became evident that the determined and somewhat impatient behavior of Dalma stemmed from how much she suffered from her condition. She wanted her pain to be mitigated as soon as possible. I had to psychoeducate her on grief along with the disadvantages of the rapid management of grief reaction and pain without invalidating her suffering and her wish to manage her situation somehow. Educating Dalma on emo-

tions and grief reactions could normalize her intense reactions on the one hand. On the other hand, by learning that grief can include a range of extreme reactions, she was able to put her own condition into a new, less catastrophizing perspective.

Apart from grief, in the case of Dalma we had to focus on her health anxiety associated with her heart condition. As a professional, I had to consider Dalma's condition as an actual risk factor. To this end, medical examination was essential. If Dalma had not initiated a medical examination, the motivational interview would have also been part of the first session as a health psychological intervention. Given that Dalma had done steps to get examined, the main lead of our work was to normalize her physical state by managing her mental state.

Similarly to psychoeducation about grieving, education on the symptoms associated with panic attacks is also important to patients experiencing panic attack-like symptoms. Dalma feared that the panic attacks she experienced would lead to the development of another disease. As Dalma described, the events she experienced triggered panic attacks; however, her anxiety was clearly linked to the recent death and the events associated with it. Thus, I classified what she experienced as an acute stress reaction. With psychoeducation, we corrected her sense of being labeled as a person with a mental disorder (i.e., panic disorder), which helped Dalma perceive her situation as more manageable. At the same time, it also prevented her fear of developing another disease.

Naturally, we cannot expect the cessation of the symptoms from this intervention only; therefore, psychoeducation must be complemented by other therapeutic elements that offer measures to manage the situation. In these cases, relaxation techniques may be considered. In the first session, as a psychologist, I always base relaxation intervention on the existing techniques of the client. The same applied to the case of Dalma on our first session. Everybody has certain stress-relieving rituals and behaviors, as well as situations that have a calming effect on them. A brief exploration of these factors can help in choosing what technique to recommend. In most cases, I teach some of the basic moves of progressive muscle relaxation (Jacobson, 1938) to clients suffering from anxiety, as it is easy to acquire. The advantages of this technique include that it can simply be linked to previous experiences, and it does not require any equipment, only the muscles and attentional focus of the clients. In an emotionally loaded situation, difficulty concentrating is commonly experienced. Thus, it is of great importance to secure an appropriate environment for teaching these techniques to the clients as this environment will be associated with a sense of peace. Nonetheless, practicing away from a somewhat safe environment is also crucial in acquiring such a technique. Accordingly, we discuss the situations with the clients in which they believe they can practice the movements of the relaxation. In the first session, I advise against immediately testing relaxation in the situation associated with the most anxiety. This is because a technique that is not wholly acquired is less likely to override the overbearing

anxiety they experience. I also advised Dalma to practice muscle relaxation in situations that (according to her) induced mild levels of anxiety. She was encouraged to observe the effects of the technique.

When Dalma recounted the events of the night of Krisztina's incident, she strikingly avoided being specific while describing the events. Instead of being concrete, her expressions were vague and obscure. This phenomenon is the equivalent of a reaction to distancing and avoidance in grief. It may help in certain cases to prevent the psyche from getting overwhelmed by the problem. This coping mechanism may temporarily help the client and may be needed in some life situations. However, psychological work should aim to reduce the use of such coping strategies. In the case of Dalma, I gave moderate, but firm feedback; it also started a discussion about distancing. Apart from encouraging her to accept the grief reaction as normal, I also tried to make her recognize that the grief process is hindered by her avoidance of telling things like they are. *"We are here together with the intention to face your fears, but it will not be easy if you cannot even name them."* A well-chosen metaphor might be of great help to start reframing in similar cases: *"I have a feeling that we are talking about this like the characters in Harry Potter talk about Voldemort whose name they dare not utter. This is actually what makes Voldemort terrifying. Harry utters his name from the beginning and is also able to face him later."* The shared knowledge needed to understand the metaphor forms a bridge between helper and client and also between the problem and the person burdened with the problem. At the same time, it must be pointed out that a metaphor that is too complex or requires too much explanation may hinder the connection and understanding. This is especially relevant if the client is in an altered state of consciousness due to grief, anxiety, or trauma or if the client's current mental state (e.g., difficulty concentrating, information processing difficulty) makes it difficult to comprehend abstract non-tangible notions.

In the first session, my therapeutic work was centered around my holding function (i.e., to hold the patient). Furthermore, I tried to normalize her experiences, support the reframing of her experiences with psychoeducation, and delineate the goals of our work. The grieving young woman's anxiety posed a professional challenge to me. I had to take multiple factors into account in this situation. On the one hand, I felt the need to support the client with some kind of intervention that improves her coping. On the other hand, I was aware that one session would not be enough to achieve remarkable reduction of the burdening symptoms. I was a bit afraid that the symptoms would intensify with the nearing of the memorial service or due to other triggers, while the existing coping would not be sufficient to manage the situation. However, I also trusted that Dalma would be able to ask for help if needed. Nevertheless, I had to take into account that her previous heart surgery was associated with some risk (the level of which was unknown for me at the time). Therefore, I could not have been sure that I had found the appropriate balance in supporting her in developing a realistic attitude

towards her symptoms. By this, I mean that first, risk factors have to be considered. Second, clients should be encouraged to avoid attributing too much importance to one symptom or another. Third, I had to think from a professional point of view about in what order to work with the problems the client had brought to me. Among panic attacks, grief work, and health anxiety, which was associated with the highest risk?

3.2. Description of the Therapeutic Process

During the second session, we decided to dedicate the next few sessions to the management of situations that trigger anxiety. We agreed to start learning the Grief Recovery Method following that. The focus of the conversation was Krisztina's memorial service. Dalma recalled painful but relieving memories regarding the event. She gained a positive experience about herself: she expected herself *"to have a breakdown";* however, it did not happen. She proudly told me about having some nights when she had been able to sleep more peacefully after calming herself down.

In the second session, Dalma introduced another topic that significantly affected her life. She talked about how her view of herself had changed. As it turned out, one of the most unexpected experiences of the grief process for her was that she felt as if the way she had described and known herself before had become distorted. She described herself as having a cheerful personality, a positive attitude, and a focus on finding solutions. Her currently anxious, highly sensitive, and almost helpless behavior was in contrast to that picture of herself. She had a recurring thought describing her experience: *"This is not me! Am I going to stay like this?"* Regarding this thought, we talked about how any loss could create a situation where things that were previously believed to be solid points become uncertain. The previously known routine could fall apart, and temporarily, no new routine would develop. A new routine would only appear as a result of successful coping with the new situations. It was clear that Dalma was experiencing an accidental crisis, so psychoeducation was conducted accordingly.

The following quote of Dalma made me realize how deep a change she experienced: *"Will I ever be able to smile truly and honestly?"* This sentence echoed between us as if even the possibility had become uncertain that this condition (which currently immobilized and kept her down) could change. This sentence and all the feelings behind it had a deeper meaning that went further than the simple questioning of capacity for joy. Although this was not the focus of our work together, it was a recurring topic from time to time that we covered.

Dalma was unsure how she would function in a group of friends and how her debilitating anxiety would impact her relationship with others, especially her partner. Dalma was afraid that she would overwhelm her partner, who was also struggling with the pain over the loss of his mother. Dalma's partner had a key role in managing Dalma's anxiety on top of all the other things. He was the one to take Dalma to the on-call family doctor; thus, he was on constant alert. Dalma believed that her anxiety did

not allow her partner to relax (e.g., at a social gathering), because he was the one she could turn to with her problems. Moreover, in some cases she felt anger if her partner did not care about the risks or thought Dalma's reaction was overexaggerated. These feelings accelerated the tension between the two. They were having arguments several times. This change made Dalma more uncertain and raised concerns in her about their relationship.

Dalma's beliefs behind her fears gradually revealed themselves during our talks. A cognitive approach to anxiety appeared to be the right method to manage the distressing thoughts that emerged from the exploration of her beliefs. Therefore, I used this approach to help her coping. During our work together, I first introduced Dalma to the cognitive approach of anxiety. During psychoeducation, I also detailed the characteristics of beliefs, negative automatic thoughts, and cognitive distortions. We identified the negative automatic thoughts and the emotional, behavioral, and physical factors associated with them during our sessions. Furthermore, I introduced her to the method of reality checking. Dalma was really open to the idea. She identified feeling tightness in the chest as the most prominent symptom of her anxiety. This bodily sensation was accompanied by thoughts that there was something wrong with her heart again or that she might have a heart attack like Krisztina. On an emotional level, she reported an increase in anxiety and insecurity, and a reduction in feeling safe. As her anxiety increased, so did her physical reactions, prompting Dalma to seek company, not be left alone without help, and take her heart medications and sedative pharmaceutical products. The avoidance behavior she developed to manage her anxiety included not going to places like closed corridors and the back staircase, where her sense of loneliness increased. To the avoidance behaviors, a belief was coupled that if she had an attack, she would not be discovered in close spaces; hence, she would not be able to receive help or ask for it. Our discussion about the possible reasons behind her bodily feelings and reactions to stress, as well as exploring the negative thought spiral helped me understand how her anxiety could escalate. This knowledge gave her another interpretation framework for understanding her own behavior, which helped her developing a more realistic image of herself and considering herself capable of dealing with the distressing situation. I also introduced her to relaxation techniques as an additional line of intervention. We practiced mindfulness relaxation with the help of a smartphone application, which became part of her life because of its easy accessibility and usability.

In addition to the management of her anxiety, we also talked about her experiences regarding grief, comprehending that the trigger was a case of death. During our work together, Dalma had to face other loss experiences (both related to relationship, family, and work) on which we focused our attention during one session. The cumulative grief events brought a transitory deterioration in Dalma's anxiety management, but as we progressed with the counseling, these relapses became shorter and shorter.

We only started to involve the Grief Recovery Method when her intense bodily symptoms reduced, and her sense of control strengthened. At that point, I also encountered a professional dilemma given that starting the grief process might significantly set back the progress made so far. Until the client's condition is not sufficiently stabilized and the new skills are not firmly established, professionals should take this risk into consideration. At the same time, based on Dalma's description of the grief events, I had a feeling that it would be unfavorable to neglect the deeper processing of grief for a longer time. The recall of loss is typically a disturbing experience, both at the beginning and later stages of the grief process. I informed Dalma about the possible relapses and the state we commonly refer to as an emotional rollercoaster in everyday life.

Since Dalma was motivated, open, and determined, we eventually began the grief processing according to the schedule of the Grief Recovery Method. The initial phase of our work together allowed us to discuss the expectations from her environment towards her regarding how to manage her grief. We also discussed the beliefs that were associated with these expectations, and we could evaluate together how much these factors limit or support her in experiencing and expressing her grief.

As we advanced with the grief processing, social events had started to reappear in Dalma's life. However, due to her emotional state, she felt like she was unable to lightheartedly attend these events, she was rather tense and stiff. Her desire to experience her presence in social gatherings as she did previously made her impatient: *"I would like to get over this all and feel well again. How long will it be this way?"* It seemed like the improvement she experienced made Dalma believe that what she had achieved would help her leave the pain behind soon, including the unusual experiences of herself and the sleepless nights caused by her anxiety. Dalma arrived at the next session with a new hairstyle and hair color, wearing colorful summer accessories. Commenting on her new look, she said: *"We cannot get stuck."* This expression seemed to serve as a motivational quote for her. It triggered her to make visible changes in her life. I have encountered similar events a few more times during our session. This told me that Dalma was starting to regain control over her life and that she now felt able to allow other kinds of experiences close to herself.

One of the deepest processing experiences during grief processing is usually the overview of the loss experiences and their placement on a timeline. I detected a significant setback in her condition after we reviewed her losses. Although having relapses is an integral part of the process, two major losses concerning her close friends contributed currently to the worsening state of Dalma. We began to process her relationship with her mother-in-law in this time period. Although the current losses deeply impacted Dalma, she was able to dedicate herself to the processing of this relationship with undivided attention. They got along well since they first met, but moving in together is what made their relationship became truly intimate. Dalma considered Krisztina a good friend, sometimes a mother, to whom she could often turn for advice and emo-

tional support in sad and uncertain situations or when facing a dilemma. Often, Krisztina was the one to help Dalma escape from her ruminative state and facilitate her to decide or take action without deciding instead of her. As a result of Krisztina's support and encouragement, Dalma continued her studies and opted for different courses. As she talked about their relationship, it felt like with Krisztina's death Dalma had lost a person who had been a pillar of her strength. Similar to most people who grieve the loss of a special relationship, Dalma's relationship with the deceased could be described as a feeling *"like losing a part of myself"*. Although the psychological interpretation of this sentence may be indicative of dependency, it is not necessarily the case. Naturally, dependency might need to be considered in some cases. However, the Grief Recovery Method, being a self-help method, does not include the processing of pathological grief processes.

In parallel with the grief processing, Dalma further improved with her anxiety management. She independently set herself new challenges to herself confronting herself with situations that had previously anxiety inducing. One example of such a situation is when she stayed at home alone for a more extended period of time. During this time, she consciously focused on not looking for a social distraction (e.g., talking on the phone) as she used to do. She reported as a success that she took time to review her negative automatic thoughts and do a reality check at the beginning, which reassured her.

After finishing the Grief Recovery Method, we met a few more times. These sessions focused on a journey and Dalma's fears with respect to the trip. Travelling abroad aggravated her fear of a sudden illness and the negative automatic thoughts she previously had. Therefore, we once again focused on practicing coping strategies and management options for a few sessions before the journey. Although being away from home and the seemingly risky situation of travelling by plane posed a challenge to Dalma, she did not experience panic reactions. She was also able to rapidly overcome her anxiety during the flight. The experiences she gained reinforced her self-image and made her more self-confident.

Another event to be highlighted was that Dalma finished a course she started before and she begun to work in the field. Her choice of profession of doing therapeutic work with dogs stemmed from her love of these animals. Initially, while grieving, she was hesitant to engage in this profession more seriously due to her timidity and feeling of being inexperienced. During our talks, she often listed counterarguments and excuses of why that was not the time to embark on this interest. What gave her a little push was a special offer. She started to work with a dog that needed to be handled especially carefully. Despite the challenging task, Dalma felt that she was able to help. Although her insecurities had not ceased, considering the effectiveness of the therapy, she was becoming more confident in her work. Because of this course, Dalma could immerse herself in an activity that she did out of intrinsic motivation.

Nearing the termination of the counseling, Dalma seemed to have returned to her old *"colors"* both according to her opinion and appearance. At the same time, she could also integrate her feelings of grief. Her experience that she was able to rise from such depths she felt stuck in increased her self-confidence and helped her acquire new skills. From the feelings of confusion, impatience, and helplessness shown during our first session, Dalma moved on to a state that she can manage and is more harmonious with her inner emotional states, characterized by more focus, patience, and control over her life. Her working as a dog therapist is an example of posttraumatic growth in grief.

Our follow-up appointment happened three months after the termination of the counseling. Dalma's work life changed for the better as she got promoted. This was associated with increased responsibility, but at the same time, it was also proof of her competence. As part of planning their future and saying goodbye to the memory of Krisztina, she and her partner packed up Krisztina's former room. Furthermore, they started to remake the room and the common rooms to better meet their needs. Dalma commented on this as follows: *"we have only started to actually become a couple."* With that, she emphasized that they could not experience how they were as a couple (e.g., in what environment they felt comfortable living in, how they liked to organize their daily life) while living with Krisztina and her younger son. They were able to take their relationship to a new level following the unexpected loss, and experiencing these changes further strengthened their relationship. Their future plans included starting a family. We had talked about them having children before, but it seemed to me that Dalma placed it into the distant future. In the follow-up session, it appeared that Dalma and her partner were preparing themselves for this commitment. The notion now seemed to be placed in the near instead of the distant future.

4. Discussion

Dalma's case illustrates the emotional changes of the relatives following an unexpected injury, illness, or loss, as discussed in the introduction section well. Experiencing bodily changes that were also limiting her daily life and an inability to cope with them prompted the young woman to seek professional help. The focus of psychological work involved interventions to manage the bodily changes and grief processing. Dalma was able to effectively employ interventions that improved coping. As a result of her motivation, ambitious and problem-centered attitude, and consciousness, she rapidly overcame anxiety-inducing situations. This case, in many ways, is an example of successful coping and effective use of resources.

Following Dalma's case, readers might easily have the impression that psychological counseling, therapy, and grief processing involving relatives is usually a smooth and successful process. In reality, however, it is more likely for the psychologists to face several relapses, stagnation, reduction in motivation, psychological and mental issues,

and social difficulties that might go beyond their competency. In these cases, the involvement of other professionals (psychiatrists, social workers) might be necessary.

The case presented here draws attention to the importance of professional self-knowledge and personal involvement. The considerable anxiety and suffering caused by grief-induced pain that can be observed in the first appointment affects the clients on a visceral level and makes them strive to get rid of these feelings as soon as possible. The psychological pressure of suffering that motivated the client to contact me was detectable in the therapeutic space. In the form of transference, I also experienced the feeling of being urged during my talk with Dalma. This automatically brought me a thought that was undoubtedly stemming from the client: *"Let's quickly do something, anything really, just to get over with it!"* I also found myself starting to think about what rapid solution I could offer her. In this context, it was important to consider what options are available for intervention and how applicable these are in the given situation without misleading the client by suggesting that her problem can be easily and rapidly solved. During the evaluation, I also had to bear in mind that along with immediate help, I had to consider professional points of view that supported the necessity of a slower and long-term process and more careful application. Offering a simple and fast solution to a problem might create false illusions and convey a message that the current situation can be effectively managed easily by investing low energy. However, this illusion falls apart fast in practice due to the nature of the problem. This might undermine the therapeutic relationship and the clients' trust in herself and the psychological work. In order to avoid this, it is of great importance to provide adequate information and check if the clients have understood the possible effects and the conditions of an effective intervention.

Psychologists should approach their job with appropriate flexibility, particularly when working with relatives at the bedside. The limited predictability and uncertainty impose a burden on psychologists as well. Thus, finding adaptive coping methods is essential to work effectively and prevent burnout.

Lessons learnt from this case

The visceral response to loss can make a person with previously effective and adaptive coping strategies helpless and insecure in their identity and daily activities with significant intensity and pace. Seeing the suffering caused by grief, panic attacks, and anxiety urges the professionals to provide effective help as soon as possible. However, the positive experience of accompanying the clients through the healing process despite the overwhelming urge for immediate help and the way we offer a range of interventions as professionals to guide the clients through the difficulties that inevitably arise during the procedure is an important lesson to learn.

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