Yas Psikolojisini Anlamak

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Özet

Yas, bir yakının kaybından sonra ortaya çıkan normal bir tepkidir ve iyileşmesi zaman alan bir süreçtir. İnsanların bir kayıptan sonra hayatlarını yeniden düzenlemek için geçirdikleri normal süreç olarak tanımlanabilir. Yas psikolojisini anlamak için, yasın teorik ve kavramsal çerçevesini anlamak ve yasın ötesine geçmek için etkili tedavi yaklaşımlarını kullanmak önemlidir. Bu bölümde, yasın teorik çerçevesinin yanı sıra yas sürecine ilişkin mitler ve kültürel çıkarımlar ile kalıcı karmaşık yas bozukluğu olarak teşhis edilen normal ve patolojik yas süreçlerinden bahsedilmektedir. Ayrıca, yas danışmanlığı, aile terapisi yaklaşımları, dışavurumcu sanat terapisi, bilişsel-davranışçı terapi, kişilerarası psikoterapi, karmaşık yas terapisi ve varoluşçu terapi gibi etkili yas terapisi yöntemlerinden bahsedilmektedir. Bu literatür taraması çalışması, yas sürecini ve psikolojisini farklı yönleriyle incelemekte, 21. yüzyıl yas terapisi yaklaşımlarının teorik çerçevesini anlayarak, yası çok boyutlu olarak tanımak, fark etmek ve çeşitli terapötik ekollerden çeşitli teknikler kullanarak bütüncül bir şekilde tedavi etmek için bir yapı sağlamaktadır.

Anahtar Kelimeler: Yas, Kalıcı Karmaşık Yas Bozukluğu, Yas Terapisi, Yas Odaklı Psikoterapi.

Understanding the Psychology of Grief

Abstract

Grief is a normal response that occurs after the loss of a close one and is a process that takes time to heal. It can be defined as the normal process people go through to readjust their lives after a loss. To understand the psychology of grief, it is important to understand the theoretical and conceptual framework of grief and use effective treatment approaches to move beyond grief. In this chapter, a theoretical framework of grief, along with myths and cultural implications about the grieving process, and normal and pathological grief processes diagnosed as persistent complex bereavement disorder are mentioned. Also, it is mentioned about effective grief therapy methods such as grief counseling, family therapy approaches, expressive art therapy, cognitive-behavioral therapy, interpersonal psychotherapy, complicated grief therapy, and existential therapy. This literature review study examines the grief process and psychology in different aspects, understanding the theoretical framework of 21st century grief therapy approaches to provide a structure to recognize and realize grief multidimensionally and treat it integratively with using several techniques from various therapeutical schools.

Keywords: Grief, Persistent Complex Bereavement Disorder, Grief Therapy, Grief-Focused Psychotherapy.

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Introduction

As humans, we all experience numerous stressors during our lives. Sometimes, these stressors can be absorbed and well-managed, but certain types may have a traumatic effect on us. Moving to a new city, accidents, loss of a body part, learning a chronic illness such as cancer, separation, divorce, financial changes, or the death of a loved one could be traumatic events that make it difficult to manage the process and adapt to a new life without that loss. Since there are different types of losses, there are various feelings and responses that both individuals and professionals must understand. Related to the deepness and meaning of the loss, people could develop psychological or psychiatric disorders or a well-internalized life experience that causes them to grow after that trauma. After losses, people may experience mourning, grief, depression, anxiety, or a combination of emotions. These mixed losses could be clarified by defining loss, mourning, and grief. Before moving beyond those feelings and related psychological and psychiatric approaches, it is better to understand the framework of those concepts and theoretical models of grief.

Conceptual Framework

Loss types could be categorized into physical, relational, and symbolic losses. Physical loss refers to concrete ones, like the deceased person, a pet, or any other tangible things such as smell or warmth of touch (Doka and Martin, 2010). Relational loss involves abstract and symbolic losses where the connection and emotional attachment are no longer there or have no chance to be the same as before, such as trust, security, social status, power, financial support, belief, health, or loss of unfinished dreams and hopes (Gross, 2016; James and Friedman, 2014). Death, divorce, and separation are loss types that could include both physical and relational losses. Bereavement differentiates from loss due to its key emphasis on intensive deep-level feelings and reactions after a traumatic physical, relational, or emotional change in one's life (Doka and Martin, 2010).

Grief is a term used with a wider spectrum, including all responses, changes, and reactions after traumatic stressors to readjust life without those lost things. Even though grief is a normal process that everyone must experience in a normal and freedom-own way to complete and move on with their life, there might be some obstacles, familiar, cultural, or religious expectations, and consolation approaches that might cause grievers to be stuck in that process. In this process, many different emotional, physical, behavioral, and intellectual reactions are observed in people. These responses change, improve, or sometimes resist healing during the grieving process. There is no definite and clear structure about how this process will proceed, as it depends on multiple variables in the person. The identity of the deceased, the way they died, the relationship with the deceased, the functionality of coping methods, making sense of death according to cultural and religious beliefs, past losses, ongoing grief, personality traits, psychological and psychiatric history, presence of functional social support level and sustainability level, physical, social, financial change, and the existence of unintentionally loaded roles after the death can be counted among these variables (Yoruk, Turkmen, Yalniz and Nebioglu, 2016; Worden, 2018).

Sometimes, the psychological adaptation of the person in the grieving process can be intensified according to the type of grief. In normal and expected types of grief, while the person begins to take part in the grieving process mentally and emotionally (Worden, 2018; Wallace, Wladkowski, Gibson, and White, 2020), in complex and traumatic types of grief, defined as the sudden and unexpected death of a person (Otani, Yoshida, and Morita, 2017; Yörük, 2016), such as not being able to attend the funeral of the person who died when social rights are deprived, as was the case with COVID-19, not being able to have a ceremony with their loved ones, or in death types involving social stigmas, such as AIDS or suicide, the reactions in the grieving process become more intense and make adaptation difficult (Gross, 2016; Savas, 2020).

In short, the term 'losses refer to any change that causes a person to experience disappointment. The term bereavement refers to the objective situation of someone who has lost someone close to them. The term 'grief' refers to the emotional experience of the psychological, behavioral, social, and physical reactions the bereaved person might experience because of the death, or any other losses that caused him deep feelings and meaning loss (Boerner, Ket al., 2015).

Grief Theories and Models

Since grief has complex processes of rumination, confrontative coping, and expression of emotion (Strobe, 2011), it is more important to see the whole picture rather than a piece of symptom, feeling, or response after the loss.

There are many theoretical approaches to understanding grieving. The first theory is from Freud (1917), as he said that a prolonged grief process is an attempt by the grieving person to redefine their relationship with the deceased, with themselves, and with the outside world. According to Freud, successful grieving occurs when the emotional bond with the deceased is cut off, and emotional energy is projected into new relationships. Freud's work paved the way for many researchers and theorists, such as Kübler-Ross, Bowlby, Rando, Doka, and Martin.

Kübler- Ross explained grief within five stages: denial, anger, bargaining, depression, and acceptance. Denial refers to the 'emotional and intellectual processing defense mechanism before acceptance of what happened (Gross, 2016). Anger refers to the reflection of anger toward own or others. Bargaining is trying to make promises or commitments to delay dying or bad days with God, own, or others. Depression is a reactive response to all loosed things and days. Acceptance is the stage of increased awareness and acceptance. Bowlby has also 4 stages of grief theory which are numbness, yearning and searching for the deceased, disorganization, and reorganization stage. Rando has a model with 3 phases: avoidance, confrontation, and accommodation. Under these 3 phases, there are 2 stages. These models emphasize that grieving stages without any discrimination and no rule-based stages progress linearly. After the loss, the grief process completion involves going back and forth between stages for a while.

Doka and Martin (1994) explained grief in terms of physical, emotional, cognitive, spiritual, and behavioral styles. Physical styles could be headaches, muscle aches, nausea; tiredness and fatigue; menstrual irregularities; loss of appetite; pain; insomnia; tension; and sensitivity to noise. Emotional styles could be sadness; anger; guilt; jealousy; fear and anxiety; embarrassment; relief; emancipation; powerlessness/despair. Cognitive styles of grief could be experiencing ruminative thoughts; difficulty concentrating; daydreaming; insensitivity; nightmares; disorientation; confusion; and reviewing the moment, way, and circumstances of the death multiple times. Spiritual styles of grief are seeking meaning in loss, contemplating the meaning and purpose of life, and changes in spiritual feelings or beliefs. Behavioral styles could be crying, outward expression of emotions, avoiding or seeking reminders of the deceased; obsessive activity (visiting a cemetery, exercise, sports, gardening, substance use), and social withdrawal. Stroebe and Schut's dual process model (1999) focuses on coping styles because they believe that the grieving process is explained based on how the person copes with the loss. Loss-oriented and restoration-oriented coping styles are the determinators of the grief processes which individuals direct their energy. Worden (2009) defines grief differently than the other theoreticians because she states that to regain control of their emotions and make sense of their life after the loss, someone must complete the unfinished works related to that loss.

Discrimination of Normal and Psychopathological Grief

Regardless of the type of loss, it affects the psychological functionality of the person. After a loss, people often express intense longing, which gradually subsides within weeks or months with sadness. The healthy grieving process is necessary for completing feelings and thoughts about the past relationship, letting go of dreams with the deceased, and accepting the current reality. This process may take from a few days up to 18 months, and variations are considered normal and understandable.

- The structure of love for the deceased and how it fits into their life begins to form within a certain period.
- Cultural, familial, and religious expectations may influence grief behaviors and attitudes, sometimes causing a secondary emotional burden.
- There is no perfect or correct way for these grief attitudes, and the process progresses specifically to the person who was lost.
- After each loss, reactions and the grieving process may proceed differently, indicating that mental and environmental restoration work is ongoing.

Normal Grief Brokers

Although it seems that grief is accepted within the population, family, and culture, it is not the same for grievers. You want to mourn, but unfortunately, there are so many sounds coming from your mind and from your outside environment that the following sentences may come:

"It's a shame no one hears or sees what people say."

"You're screwed up; come to yourself, look at you, you're exhausted from crying, eat some food."

"It is a sin; God does not like mourning for 3 days. Our prophet cried for 3 days, and then the bones of the deceased ached."

On the one hand, you want to do something to feel good, to stand up, but again, those around you and the voices in your mind will not shut up. Or have you never felt sad? What are you watching on TV? Have you put on makeup? Have you no shame? Do you ever go to dinner, go out, stop for 7 days, or 40 days? Look at what you've done, your clothes... his bones are aching there... it turns out who he sacrificed for, what he ruined his life; he's gone... In addition, there are suggestions for solutions and insistence parts that come both from the mind and from outside... Look ahead. The nail rips out the nail. Life goes on. It passes with time. Nevermind... These things that are said are so easy to say... it's not evil at all because they are suggestions that are objective... it's just emotionless, insensitive, and lacking empathy at a high level... that is, a set of discourses that are useful at all and painful at the highest level. However, the main need of the bereaved person is to touch the heart of what he hears with his ear...

Psychopathological Grief

Just as it is not correct to assume that people who have experienced a loss will not experience psychiatric or psychological deterioration during the grieving process, it is also not correct to expect them to experience such a thing because grieving is an individual process and can be experienced in different ways and times, with different reactions (Moorey and Greer, 2011). Everyone has methods that they believe are personally effective for coping with the grieving process after a loss. Colin Murray Parkes (1986), in his pioneering work in this field, saw that the methods that work were keeping oneself busy, believing that the deceased was still with them, and relying on the support of family and close friends. If the grieving period is managed in a healthy way, in other words, if the person can continue his work, social, and family life in a balanced and stable manner despite all the fluctuations and longing inside, if they can keep up with the days, life, and themselves, there is no need for any counseling. In 3 weeks to 3 months, if the deceased was a loved one, the person will place the deceased in their heart eternally, and if the deceased was not a loved one, the person will complete the remaining feelings and thoughts and send the deceased from their mind. However, if the turmoil in work, social, and family life lasts longer than expected, and if mood swings continue, this may lead to an adjustment disorder. If it is not noticed and resolved at the level of an adjustment disorder, it will continue with a wide spectrum, such as mood swings, anxiety, obsession, trauma, and persistent complex bereavement disorder. The grief process for approximately 10% of people becomes more complicated, and they have difficulty managing the grief process after loss (Neimeyer, Harris, Winokuer, and Thornton, 2022). These individuals do not or do not want to cope with the loss through functional methods or do not feel the strength to struggle even if they want to. For whatever reason, they cannot maintain the necessary adaptation to life with the deprivation experienced after loss and continue to engage in non-existent aspects, even if they do not exist (Prigerson et al., 2008). All these unrealistic and avoidant attempts to deny the truth intensify. The longer it takes, the more it turns into an inescapable spiral, imprisoning their thoughts of the present and the future of their whole life. The person gradually begins to fail to realize that the situation has evolved beyond love and has reached a pathological dimension. This situation brings about psychiatric disorders.

Prolonged Grief Disorder (PGD): Grief, first described by Freud in 1917, is deemed a normal, non-pathological, painful yet healthy experience that should unfold within a certain timeframe. However, if this obligatory and time-limited ordeal persists, preventing the emotional detachment and transition to new relationships, Freud suggests it transforms into 'pathological grief-melancholy-depression.' The inability to convey, delay, or ignore grief reactions due to various factors—social, cultural, traditional, religious, social norms, family dynamics, or personal beliefs—complicates the grieving process.

While it is anticipated that pain would diminish over time, grief reactions intensify, causing regression and elongating the period before completing necessary emotional processes. Identified risk factors for prolonged grief include personal psychological fragility, circumstances of the manner of death, and contextual circumstances of death (Neimeyer, Harris, Winokuer, and Thornton, 2022). Psychological fragility risk factors encompass a history of mood disorders, avoidant or anxious attachment, and a history of trauma or multiple loss. Factors heightening risk in the conditions of death include untimely, unexpected, violent, or seemingly preventable deaths. Risk factors in the contextual circumstances of death involve inadequate or toxic social support and intense financial hardship.

Persistent Complex Bereavement Reaction and PGD: The natural grieving process can be prolonged when functional management is hindered by various factors. This extension negatively impacts daily life, work, family, and social interactions on cognitive, emotional, physiological, and behavioral levels. Such deteriorations may progress into psychiatric disorders. Assessment for psychiatric disorders follows the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD-11). PGD is explicitly defined in ICD-11 as impairment of functioning for life, accompanied by mental and physical preoccupation with the loss of a loved one, intense emotional pain, longing, or related feelings persisting for 6 months or more (WHO, 2019). People meeting the diagnostic criteria for PGD often experience denial of loss, identity disorder, loneliness, feelings of meaninglessness, and emotional disconnection. Symptoms include intense sadness, acute grief with longing and mourning, persistent thoughts about the deceased, difficulty imagining a purposeful future, dysfunctional thoughts, and complex, maladaptive approach and avoidance behaviors (Malgarol, Maccallum and Bonanno, 2018).

The key difference between PGD and Persistent Complex Bereavement Disorder (PCBD) lies in the duration of symptoms: 6 months for PGD and over 1 year for PCBD. Given this distinction, ICD-11 PGD is included to avoid confusion and provide a definitive diagnostic classification. PGD symptoms share similarities with other psychiatric disorders, leading to potential confusion and comorbidities. Symptoms resembling depression disorder may be mistaken for major depressive disorder, especially if experienced after the loss and with a history of depressive episodes. Furthermore, PGD symptoms may be confused with post-traumatic stress disorder, sleep disorder, or adjustment disorder. Additionally, comorbidities such as depression, anxiety disorder, and post-traumatic stress disorder may develop alongside PGD (Komischke-Konnerup et al., 2021).

To avoid confusion in diagnostic assessments, in addition to psychiatric and psychological evaluations, clinical interviews, and observations, Turkish versions of scales developed for prolonged diagnoses, with validated reliability tests, can be used. Some of these scales are detailed below:

- Post-Traumatic Embitterment Disorder (PTED) Scale: Developed by Linden, Baumann, Lieberei, and Rotter (2009), its validity and reliability for Turkish were confirmed by Ünal et al. (2011). The scale aims to evaluate the embitterment of an individual following negative experiences.

- Unfinished Business in Bereavement Scale-Brief Form (UBBS-BF): The UBBS form developed by Holland et al. was found to be valid and reliable for Turkish by Soysal (2020). UBBS has sub-dimensions that determine unresolved life and conflicts of people. Thus, it identifies things not experienced and unresolved internal complexities of a person after the loss.

- Inventory of Complicated Grief (ICG): Developed by Prigerson et al. (1995), it was found to be valid and reliable for Turkish by Atak et al. (2012). The purpose of this scale is to determine the work and social functionality, sleep problems, and suicide tendencies of individuals who experienced the death of a person they were close to in the previous 6 months or more recently (Prigerson, Maciejewski, Reynolds, 1995; Shear et al., 2011).

- Prolonged Grief Disorder Scale-Patient Form: The PGD scale developed by Thornicroft and Patel (2014) emerged with the combination of the inventory of complicated grief and the ICD-11 PGD diagnostic criteria. Validity and reliability of the scale for Turkish were established by Danışman, Yalçınay, and Yıldız (2015). This scale is a suitable tool for measuring the symptoms of grief experienced by cancer patients that start with the diagnosis and continue with all the other triggers that lead to a sense of loss. The scale has different forms, such as the patient form adapted for cancer patients (PG-12-Patient Form; Jacobsen et al., 2010), a form for relatives giving care (PG-12 Caregiver Form; Prigerson et al., 2009), and another form adapted for individuals who have lost someone they loved (PG -13; Prigerson et al., 2008).

- Two Track Model of Bereavement Questionnaire/TTBQ: Developed by Rubin et al. (2009) and adapted into Turkish by Ayaz, Karancı, and Aker (2013). To evaluate possible grief situations in individuals after death, the questionnaire includes questions about the relationship aspect of active grief, close and positive relationships established with the person they lost, traumatic perception of grief, conflict relations with the lost person, and deterioration in social functionality. Thus, the level of grief after the loss and the existence of areas that it affects and deteriorates are determined.

Moving Beyond Grief

There are different therapeutic approaches that mental health professionals use to help people grieving. Although different approaches use different techniques, their major goal is to help the griever to adapt the loss and adjust his remaining life without loss. Effective therapeutic approaches could be grief counseling, family therapy approaches, expressive art therapy; cognitive-behavioral therapy, interpersonal psychotherapy, complicated grief therapy, and existential therapy on grief.

Grief Counseling: Grief counseling is an effective approach to supporting individuals experiencing grieving symptoms without pathological dimensions or at the level of psychiatric disorder. The targets of grief counseling include:

1. Helping the person accept physical and emotional separation and adapt to life without the lost person.
2. Ensuring the transfer of emotion and supporting the sharing of emotions related or not related to the grieving process.
3. Addressing emotional blockages and providing active coping mechanisms through information and psychoeducation about the healthy and normal grieving process.
4. Offering models of problem-solving (Kahraman, 2021).

Family Therapy Approaches*:* Sharing feelings of grief after a person's passing helps alleviate emotional burdens, particularly within functional family dynamics. The involvement of family members in the grieving process facilitates mutual support, making it easier to make sense of life again and adapt. Family therapy approaches aim to:

1. Strengthen the natural support system of individuals.
2. Optimize relations with family members and reduce communication barriers for functional family dynamics.
3. Provide a safe space for the expression of feelings, wishes, and needs, increasing the sense of acceptance and understanding (Kissane et al., 2006; Neimeyer, Harris, Winokuer and Thornton, 2022).

The psychological support needs of individuals and families, as well as family therapy methods, may vary depending on the factors initiating the grieving process. For instance:

- In families dealing with palliative care or terminal cancer patients, an evaluation inventory such as the family relations index (Moos and Moos, 1981) is used.
- The therapy process involves family members participating together after a quick assessment of family dynamics, communication barriers, and problem-solving approaches (Kissane, 2000; Edwards and Lavery, 2005).
- Family therapy helps evaluate blockages related to caring for a family member in the death process, effects of role changes, expectations, and other family dynamics.

After the death, family therapy aims to explain coping methods related to emotions, reactions, and relationships experienced in the normal grieving process. It enables individuals in the family to understand each other's coping methods in emotion, thought, relationship management, and problem-solving approaches. This reconnection leverages strengths in the family dynamic, leading to increased understanding, commitment, tolerance, and forgiveness. The therapist should possess advanced micro-skills such as understanding, cooperation, sincerity, and a compassionate approach while maintaining balance in accepting each other with respect. Asking questions in a circular structure that piques individuals' curiosity is essential. Tools such as the 3-generation genogram can be used to support acceptance, empathy, understanding, and reduce blaming, focusing on the functional family dynamic and how to develop and increase it within the family structure.

Expressive Art Therapy: Expressive art therapy is a discipline that encompasses various creative art therapies, such as music, art, drama, poetry, dance, psychodrama, and bibliotherapy (McNiff, 2009). The common ground of these disciplines is to make room for the unrestricted concretization of imagination (Jung, 1997). It provides the bridge between the deeper world inside and the outside world (McNiff, 2009). Expressive art therapies, including techniques such as drawing, animating, playing, or singing, prove effective when individuals in the grieving process struggle to verbally express their feelings and thoughts, have insufficient emotion transfer skills, or cannot analyze their inner reactions (Sands and Tennant, 2010; Neimeyer, Harris, Winokuer, and Thornton, 2022). Techniques usually proceed with the client's exploratory responses to the therapist's questions conveyed through stories. Through the client's creativity, concretization skills, and metaphors, movement to the therapeutic dimension occurs (Levine, 2009; Romanoff and Thompson, 2006; McNiff, 2009). Questions asked through concepts of grief and loss in pictures, words, movements, sounds, or dramatic reenactments help the person recast their memories of the loss, the physical and emotional separation process, and make sense of life (Neimeyer, Harris, Winokuer, and Thornton, 2022).

Cognitive Behavioral Therapy: Cognitive-behavioral therapy, according to the cognitive-behavioral grief therapy developed by Boelen, Van den Hout, and Van den Bout (2006) based on the cognitive-behavioral therapy of Dr. Aaron Beck, is founded on three factors that make up the foundation of complicated grief: The first factor is that the person experiences shock at every new situation and confrontation related to the deceased person and is not able to adequately remember and connect memories, feelings, and relationships. The second factor is that people with more negative and pessimistic thinking styles have a higher risk of developing complicated grief after a loss (Hayes et al., 1996). This is because, according to cognitive therapy, if basic beliefs such as worthlessness, inadequacy, and powerlessness are not self-initiated by the person themselves but a structure they have developed so far with relation to another person or life, then they will experience a shock to their core. Examples of this are beliefs that are directly related to oneself, such as "I can never live without my father," "If I don't have my child, life has no meaning," and "I can't smile ever again, I'll be a living corpse." In addition to oneself, they may have negative catastrophic false beliefs about sharing or ending the pain, such as 'If I talk about my pain, I will lose control' or 'if I don't feel sorry for him, people will think I don't love him.' The third factor is that the person frequently uses anxious and depressive avoidance strategies (Boelen and Van den Bout, 2010). Considering these three basic factors, the therapist creates the client's cognitive formulation. The following can be considered when planning treatment: Automatic thoughts, intermediate beliefs, and core beliefs are discovered at the pace of the client, and dysfunctional ones can be replaced with functional ones. The client can be supported to adapt to work, family, and social life with healthy and balanced relationships and increase adaptive methods instead of dysfunctional coping methods. Further attempts can be made to realize emotional separation from the deceased, focusing on strengths and determining how the client wants to place the deceased in their life while succeeding in living without them.

Interpersonal psychotherapy*:* Interpersonal Psychotherapy (IPT) was developed by Gerald Klerman (1929–1992) as a short-term, solution-oriented approach structured in 12–16 sessions. According to Klerman, just as psychiatric drugs are tested before they are presented to the public, psychotherapy intervention manuals should also be researched (Sharf, 2015). Klerman created a structured program by integrating symptoms specific to grief into the practice of interpersonal psychotherapy, in which trial studies were conducted with people suffering from depression. The main purpose of this program is to change sadness, which includes giving up on both life and dreaming for the future, not being able to enjoy life, not wanting to do things they used to do, and withdrawing oneself in the grieving process, and rekindle their interest in relationships and support participation in both relationships and activities. Four areas related to the individual in the grieving process are focused on: experiencing functional grief, interpersonal conflict, role transformation, and dysfunctional interpersonal deficiency (Sharf, 2015).

Interpersonal Conflict: This helps the person develop a non-depressed perspective by raising awareness and consciousness about the perspective and perception caused by depression with everyone, at any age other than oneself. In this way, the individual can have realistic expectations about the problem they are experiencing and their communication with others. These can be shared, and if these expectations do not change when shared, they can be changed, and the dispute can be resolved. The main goals in resolving interpersonal conflict are to define the conflict, determine the action plan, develop realistic expectations, and eliminate the miscommunications that prevent them from reaching said expectations. Effective strategies to achieve these goals begin with a review of depression symptoms. It is ensured that the client discovers the relationship between the dispute in their communication with others, the onset of symptoms of depression, and the dispute they have with other people. The stage caused by the dispute is identified and approached accordingly: 1. Renegotiation (calming down participants to facilitate resolution) 2. Impasse (increasing disharmony to restart negotiation) 3. Dissolution (grief counseling) (Sharf, 2015). Another

technique is to understand how nonreciprocal role expectations are related to disputes. In implementing this strategy, the following questions can be addressed: What are the apparent problems in the conflict? What is the main, unseen problem? For each conflicting individual, what is the main source of need for dispute and what is the desired expectation? What are the differences in expectations and values? What are the options other than dispute to this extent? What is the likelihood of finding alternatives? What is needed to resolve this dispute? If it is resolved, what effect change will occur for all parties?

Role Transition: To functionally transition into the new role that has emerged after the loss, it is necessary to let go of the old one first. If one does not leave the former role behind, the process of being in between continues, creating a sense of belonging between roles, a decrease in self-confidence and self-efficacy, and difficulty in adaptation. To prevent this, it is attempted to help the individual see the positive aspects of the new role and increase their control by strengthening belonging and self-efficacy (Sharf, 2015). The main goals for returning to the role brought by the changing life after the loss in a healthily and functionally manner are as follows: Grieving the loss of the old role, completing it and to acceptting it by leaving it behind, to help the patient regard the new role as more fitting and positive, to increase the sense of belonging to the new role, and to help the individual establish control. Effective strategies to achieve these goals are as follows: Reviewing the depressive symptoms related to the role, associating the difficult parts of the current life change with the depressive symptoms, seeing the positive and negative aspects of the old and new roles completely, exploring the feelings about the loss and providing ventilation, exploring the feelings about the change itself, exploring opportunities that come with the new role, realistically evaluating what is lost, and encouraging acceptance, to encourage asking for support whenever they need it and learning the new skills required for the new role (such as assertiveness) (Sharf, 2015).

Interpersonal Deficiency: Whether in the normal grieving process after the loss or at the level of psychological disorders, there can be a period when one prefers to be alone, and isolated from social life and people. It is necessary and healthy to complete this isolation for a while, to face the past and give up on dreams for the future, to accept reality, and to return to the present. However, when this process is prolonged, it leads to disconnection from others, ignoring or suppressing problems before they are resolved, leaving them unsolvable, and leads one away from setting new healthy functional goals, establishing, and developing relationships. It is necessary to eliminate the interpersonal deficiencies in these isolations and to improve the grief-based depressive mood (Sharf, 2015). The main goals to be improved in interpersonal deficit can be reducing social isolation and encouraging the patient to establish new relationships. Effective strategies to achieve these goals are as follows: Reviewing depressive symptoms, explaining the relationship between depressive symptoms, social isolation, and feelings of loneliness, helping the patient to fully see the positive and negative aspects of their previous significant relationships, and exploring the repetitive cycles in their relationships.

Complicated grief therapy: Complicated grief therapy is a structured approach that combines attachment theory with cognitive therapy, interpersonal psychotherapy, and motivational interviewing (Shear, and Gribbin Bloom, 2017). The structuring of all sessions follows the principles of cognitive therapy: mood assessment, setting the agenda, going over the homework, working on the agenda for the day, rehearsing the homework, and discussing how to apply it until the next meeting, solving possible obstacles, session summary, and conclusion. Complicated grief therapy consists of initial, intermediate, and termination phases, completed in 16 sessions. The first phase, lasting between 1 and 3 sessions, focuses on forming the therapist-client alliance, transferring information about complicated grief, discussing the client's loss story, and setting therapy goals. Psychoeducation is provided to the client, including the similarities and differences between normal grieving, complicated grief disorder, and healthy grieving (Shear, and Gribbin Bloom, 2017).

In the second phase (4–9 sessions), the goal is to help the client accept death, find a satisfying 'new normal,' and reduce avoidance mentally, behaviorally, and experientially. Techniques involving death, blending therapist-client interaction with cognitive therapy and interpersonal psychotherapy, are emphasized. Ruminative thoughts are identified and practiced with effective techniques, addressing the client's preoccupation with making sense of death.

The third phase, termination sessions, involves reviewing the process, discussing feelings about the sessions ending, and planning for the future. Termination of cognitive therapy can be shaped by a supportive session setting to emphasize the client's empowerment before leaving. The focus is on achievements, completion of goals, the impact of the learned strategies in the post-therapy period, and addressing possible blockages and solutions (Neimeyer, Harris, Winokuer, and Thornton, 2022).

Existential therapy: considers the individual's biopsychosocial needs in treatment planning. When consulting a psychologist after the death of a loved one, the treatment plan's basic building block involves making sense of existence again. Issues related to existence, such as being alive, understanding one's purpose, and coping with loneliness, are addressed using existential psychotherapy techniques. Emotions like guilt, anger, and uncertainty are explored to provide functional ventilation for the client.

Logotherapy: Logotherapy developed by Viktor E. Frankl (1920), aims to help individuals find the meaning of their lives and discover the purpose of their existence. This therapy emphasizes attitudes rather than behavioral techniques, as a change in attitude can lead to effortless behavioral changes (Lukas, 1998). According to existential therapy, people have a unique purpose in coming into the world, examining how individuals cope with each experienced situation, trauma, and disappointments, and how they position the reality of death to ensure their uniqueness. According to Frankl, this uniqueness is realized with the meaning given to each situation, in other words, with the logo (van Deurzen et al., 2019).

Individuals stating that their life has lost meaning after a loss can find meaning again, exploring the meaning of their existence. While individuals discover how they cope with the stressors throughout their lives and how these coping methods affect them, they increase resilience and improve their ability to grow after trauma (Southwick, Lowthert, and Graber, 2016). Logotherapy is an effective psychological approach for individuals experiencing prolonged grief after death (Southwick, Lowthert, and Graber, 2016).

When working on grief with logotherapy, the therapy process is structured into five stages (Maniacek, 1982). The first stage involves establishing communication, with the therapist allying with the client through empathy, active and effective listening, sincerity, restraint, and trust. The second stage is the assessment of the situation, emphasizing the meaning of the deceased, their place in the client's life, their importance, and the client's conscious or unconscious defense mechanisms and coping methods.

The third stage involves the therapist's efforts to confront the client with their fears. The fourth stage is for the client to fill in the emptiness after the loss with constructive functional alternatives. The final stage includes termination practices, during which the client evaluates death, the deceased, themselves, and life, and re-evaluates their current problems and plans (Maniacek, 1982).

When motivation is needed, the motivational attitude technique defined by Lukas (1998) can be used. This technique comprises five steps: defining the problem behavior, determining areas where freedom of action exists despite everything (distress, reluctance, apathy, etc.), identifying all possible options through cognitive exercises, determining the most meaningful and functional option, and making the choice despite all obstacles (reluctance, fear, etc.) (Batthyány, 2016).

Another technique in logotherapy is the personal existence analysis method. This method examines how the person is affected while explaining who they are, exploring the emotions, thoughts, and reactions in this experience. Emphasis is placed on recognizing the unrealities in this emotional, thought, and reaction dynamic, repositioning them emotionally and intellectually, and expressing an effective internal movement in tangible terms.

Meaning-centered therapy: Meaning-centered therapy developed by Breitbart et al. (2010) and based on Frankl's logotherapy, integrates cognitive behavioral therapy and positive psychotherapy. It was originally designed to help patients with advanced cancer discover the meaning of life. The therapy is structured to enhance the psychosocial well-being of individuals across seven sessions for individuals and eight sessions in group format with existential content (Breitbart et al., 2010; Vos et al., 2017). Building upon meaning-centered therapy, Lichtenthal and Breitbart (2015) developed meaning-centered grief therapy specifically for parents coping with the death of a child due to cancer. This grief therapy maintains the same content, with the theme and focus shaped according to the ways of surviving despite the enormous pain experienced (Lichtenthal et al., 2019).

Post-traumatic growth after grief: *Increased Self Power*

Individuals often employ personal coping methods to navigate the grieving process after a loss. Colin Murray Parkes (1986), a pioneer in this field, emphasized the importance of engaging in life, maintaining a belief in the continued presence of the deceased person, and seeking support from family and close friends. A healthy management of the mourning period involves the ability to resume daily activities, social interactions, and family life in a balanced and

stable manner despite internal fluctuations and longing. If an individual can successfully integrate the loss into their life within the timeframe of 3 weeks to 3 months, either by cherishing the memory with infinite dimensions or by processing and letting go of remaining feelings and thoughts, formal counseling may not be necessary. However, if disruptions persist in social and family life beyond the expected period, and mood fluctuations continue, it may lead to a range of mental health issues such as mood disorders, anxiety, obsession, trauma, and persistent complex bereavement disorder. Even if not immediately recognized, this condition can progress to the level of adjustment disorder.

A minority may struggle to navigate the grieving process. Whether due to ineffective coping methods, unwillingness to cope, or a perceived lack of strength to fight, some individuals may struggle to adapt to life after experiencing loss. For various reasons, they may find it challenging to reconcile with the deprivation brought on by the loss, persisting in a connection with those who are no longer present (Prigerson et al., 2008). Attempts to avoid confrontation with the truth and indulge in unrealistic thinking can intensify and prolong, creating a spiral that imprisons their thoughts, present, and future. In such cases, individuals may gradually lose sight of the fact that their situation has moved beyond a natural grieving process into a pathological dimension, becoming an invitation to psychiatric disorders.

Conclusion

Loss, pain, the search for meaning, emotional confusion, and difficulty readapting to daily life after the death of a loved one constitute a normal and natural process that every person may experience. However, if the intensity, severity, and negative effects of this process on daily life and future goals persist even after 12 months, it is considered a complicated grief disorder. In such cases, psychiatric and psychological support may be required, as the circumstances deviate from their normal course.

Effective approaches in the field of psychological support include grief counseling, family therapy approaches, grief psychotherapy, and expressive art therapy (such as cognitive-behavioral therapy, interpersonal psychotherapy, complicated grief therapy, and existential therapy). Regardless of the specific approach used based on the individual's needs, the priority in this process is the alliance and trust relationship that the therapist establishes with the client through the effective use of micro skills. Approaches that prioritize and incorporate this alliance and awareness will facilitate the grieving person's journey to find meaning again after the loss and regain a sense of belonging and participation in life.

References

Ayaz, T., Karanci, A. N., ve Aker, A. T. (2014). İki boyutlu yas ölçeğinin Türkçe formunun geçerlik ve güvenirlik çalışması. [Validity and reliability study of the Turkish form of the two-dimensional grief scale]. Turk Psikiyatri Dergisi, 25, 253-263.

Batthyány, A. (Ed.). (2016). Logotherapy and existential analysis. Cham: Springer.

Black, D. W., and Grant, J. E. (2014). DSM-5® guidebook: the essential companion to the diagnostic and statistical manual of mental disorders, American Psychiatric Pub.

Boelen, P. A., Van Den Hout, M. A., and Van Den Bout, J. (2006). A cognitive-behavioral conceptualization of complicated grief. Clinical Psychology: Science and Practice, 13(2), 109.

Boelen, P., and Van den Bout, J. (2010). Anxious and depressive avoidance and symptoms of prolonged grief, depression, and post-traumatic stress disorder. Psychologica Belgica, 50(1-2).

Boerner, K., Stroebe, M. S., Schut, H. A. W., Wortman, C., and Pachana, N. A. (2015). Theories of grief and bereavement. Encyclopedia of geropsychology.

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., ... and Nesse, R. M. (2002). Resilience to loss and chronic grief: a prospective study from preloss to 18-months postloss. Journal of personality and social psychology, 83(5), 1150.

Breitbart W, Rosenfeld B, Gibson C, Pessin H, Poppito S, Nelson C, et al. Meaning centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial. Psychooncology, 2010;19(1):21–28.

Currier, J. M., Holland, J. M., and Neimeyer, R. A. (2006). Sense-making, grief, and the experience of violent loss: Toward a mediational model. Death studies, 30(5), 403-428.

Danışman, I. G., Yalçınay, M., ve Yıldız, N. (2017). Kanser Hastalarında Yas Belirtilerinin Ölçülmesi: Uzamış yas bozukluğu ölçeği Türkçe formunun geçerlik ve güvenirlik çalışması. [Measuring Bereavement Symptoms in Cancer Patients: The validity and reliability study of the Turkish version of the prolonged grief disorder scale]. Türk Psikiyatri Dergisi, 28(3), 190-7

Erdem Atak I, Beyazıt U, Subay N, Sarı B, Kokucu G, Ünverdi H, ve ark. (2012). Karmaşık Yas Envanteri (revize edilmiş formu)'nun Türkçe'ye çevirisi: Geçerlik ve güvenirlik çalışması. [Turkish translation of the Complex Grief Inventory (revised¸ form): Validity and reliability study]. 17. Ulusal Psikoloji Kongresi Poster Bildirisi, [17. National Psychology Congress Poster Statement] Istan¸ bul.

Freud, S., (1997). Mourning and Melancholia. Standard Edition, Strachey J. (Ed), 14, Hogart Press, London 1917 (Trans. Uslu, R., Berksun, O.), Kriz Dergisi, 1; 98-103.

Gamino, A., Kenneth W. Sewell, Larry W. Easterling, L. (2000). Scott and White grief study phase 2: Toward an adaptive model of grief. Death Studies, 24(7), 633-660.

Gross, R. (2016). Understanding grief: An introduction. Routledge.

Harrington, J. A., and Neimeyer, R. A. (Eds.). (2020). Superhero Grief: The Transformative Power of Loss. Routledge.

Harris, C. B., Brookman, R., and O'Connor, M. (2021). It's not who you lose, it's who you are: Identity and symptom trajectory in prolonged grief. Current Psychology, 1-11.

James, J. W., and Friedman, R. (2014). The Grief Recovery Handbook. 20th Anniversary Expanded Edition (224). Harper Perennial.

Jung, C. G. (1997). Jung on active imagination: key essays selected and introduced by Joan Chodorow. London: Routledge.

Kahraman, S. (2021). Yas süreçleri ve kişilik. [Grief processes and personality]. Iksad yayınları.

Komischke-Konnerup, K. B., Zachariae, R., Johannsen, M., Nielsen, L. D., and O'Connor, M (2021). Co-occurrence of prolonged grief symptoms and symptoms of depression, anxiety, and posttraumatic stress in bereaved adults: A systematic review and meta-analysis. Journal of Affective Disorders Reports, 4, 100-140.

Köroğlu E. (Trans. Ed.). Amerikan psikiyatri birliği. ruhsal bozuklukların tanısal ve sayımsal el kitabı beşinci baskı (DSM-5). [American psychiatric association. Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5)]. Ankara: Hekimler Yayın Birliği, 2014, 1094-1098.

Lazarus, R. S., and Folkman, S. (1984). Stress, appraisal, and coping. Springer publishing company.

Levine, S. K. (2009). Trauma, tragedy, therapy: The arts and human suffering. London: Jessica Kingsley.

Lichtenthal, W. G., and Breitbart, W. (2015). The central role of meaning in adjustment to the loss of a child to cancer: Implications for the development of meaning-centered grief therapy. Current opinion in supportive and palliative care, 9(1), 46.

Lichtenthal, W. G., Catarozoli, C., Masterson, M., Slivjak, E., Schofield, E., Roberts, K. E., ... and Breitbart, W. (2019). An open trial of meaning-centered grief therapy: Rationale and preliminary evaluation. Palliative and supportive care, 17(1), 2-12.

Lichtenthal, W. G., Cruess, D. G., and Prigerson, H. G. (2004). A case for establishing complicated grief as a distinct mental disorder in DSM-V. Clinical psychology review, 24(6), 637-662.

Linden, M., Baumann, K., Lieberei, B., and Rotter, M. (2009). The post-traumatic embitterment disorder self-rating scale (PTED scale). Clinical Psychology and Psychotherapy: An International Journal of Theory and Practice, 16(2), 139-147.

Lumb, A. B., Beaudry, M., and Blanchard, C. (2017). Posttraumatic growth and bereavement: The contribution of self-determination theory. Omega: Journal of Death and Dying, 75, 311-336. doi:10.1177/0030222816652971

Maccallum, F., and Bryant, R. A. (2013). A cognitive attachment model of prolonged grief: Integrating attachments, memory, and identity. Clinical Psychology Review, 33(6), 713-727.

Malgaroli, M., Maccallum, F., and Bonanno, G. A. (2018). Symptoms of persistent complex bereavement disorder, depression, and PTSD in a conjugally bereaved sample: a network analysis. Psychological Medicine, 48(14), 2439-2448.

Malkinson, R. (2013). Bilişsel yas terapisi: Bir yakınını yitirdikten sonra yaşamın anlamını yeniden yapılandırma. [Cognitive grief therapy: Reconstructing the meaning of life after the loss of a loved one]. Trans. S. Kunt-Akbaş). Ankara: Hekimler Birliği Yayınları. (Published in Cognitive Grief Therapy, 2007).

Maniacek, M. A. (1982). Logotherapy: A grief counseling process. In International Forum for Logotherapy. Viktor Frankl Inst of Logotherapy.

McNiff, S. (2009). Integrating the arts in therapy: History, theory and practice. Springfeld, IL: Charles C. Thomas.

Moorey, S., and Greer, S. (2011). Oxford guide to CBT for people with cancer. Oxford University press.

Neimeyer, R. A., Harris, D. L., Winokuer, H. R., and Thornton, G. F. (2011). Grief and bereavement in contemporary society: Bridging research and practice. Routledge.

Parkes, C. M. (1986). Bereavement: studies of grief in adult life. London: Penguin Books.

Prigerson, H. G., Maciejewski, P. K., Reynolds III, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., ... and Miller, M. (1995). Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. Psychiatry research, 59(1-2), 65-79.

Prigerson, H., G, Vanderwerker, L., C ve Maciejewski P., K. (2008) A case for inclusion of prolonged grief disorder in DSM-V. In: Stroebe M, Hansson R, Schut H and Stroebe W, eds. Handbook of Bereavement Research and Practice: 21st-century perspectives, 165–86. Washington, DC: American Psychological Association.

Romanoff, B., and Thompson, B. (2006). Meaning construction in palliative care: The use of narrative, ritual, and the expressive arts. American Journal of Hospice and Palliative Medicine, 4, 309–316.

Rubin, S. S., Bar Nadav, O., Malkinson, R., Koren, D., Goffer-Shnarch, M., and Michaeli, E. (2009). The Two-Track Model of Bereavement Questionnaire (TTBQ): Development and validation of a relational measure. Death Studies, 33(4), 305-333.

Sands, D., and Tennant, M. (2010). Transformative learning in the context of suicide bereavement. Adult Education Quarterly, 60(2), 99–121.

Savaş, E. (2020). COVID-19 Sürecinde yas. [Grief in COVID-19 Pandemic]. Türkiye Sosyal Hizmet Araştırmaları Dergisi, 4(3), 82-89.

Schut, M. S. H. (1999). The dual process model of coping with bereavement: Rationale and description. Death studies,23(3), 197-224.

Sharf, R. S. (2015). Theories of psychotherapy and counseling: Concepts and cases. Cengage Learning.

Shear, M. K., and Gribbin Bloom, C. (2017). Complicated grief treatment: An evidence-based approach to grief therapy. Journal of Rational-Emotive and Cognitive-Behavior Therapy, 35(1), 6-25.

Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., ... and Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. Depression and anxiety, 28(2), 103-117.

Shear, M. K., Wang, Y., Skritskaya, N., Duan, N., Mauro, C., and Ghesquiere, A. (2014). Treatment of complicated grief in elderly persons: a randomized clinical trial. JAMA psychiatry, 71(11), 1287-1295.

Southwick, S. M., Lowthert, B. T., and Graber, A. V. (2016). Relevance and application of logotherapy to enhance resilience to stress and trauma. In Logotherapy and existential analysis (pp. 131-149). Springer, Cham.

Soysal, G. C. (2020). Kayıp yaşantılarında bitmemiş işler ölçeği-kısa form: Türkçeye uyarlama, geçerlilik ve güvenilirlik çalışması. [Unfinished works in loss experiences scale-short form: Turkish adaptation, validity and reliability study]. Anadolu Psikiyatri Dergisi, 21, 23-30.

Stroebe, M. S., and Schut, H. (2001). Meaning making in the dual process model of coping with bereavement. In R. A. Neimeyer (Ed.), Meaning reconstruction and the experience of loss (pp. 55–73). Washington, DC: American Psychological Association.

Ünal, Ş., Güney, S., Kartalcı, Ş., ve Reyhani, İ. (2011). Travma Sonrası Hayata Küsme Bozukluğu Ölçeğinin (PTED Self-Rating Scale) Türkçe uyarlamasının geçerlilik ve güvenilirlik çalışması. [The validity and reliability study of the Turkish version of the Post Traumatic Embitterment Disorder Scale (PTED) Self-Rating Scale]. Düşünen Adam Psikiyatri ve Nörolojik Bilimler Dergisi, 24(1), 32-37.

Van der Houwen, K., Stroebe, M., Schut, H., Van den Bout, J., and Wijngaards-de Meij, L. (2010). Risk factors for bereavement outcome: A multivariate approach. Death Studies, 34, 195–220.

Van Deurzen, E., Craig, E., Längle, A., Schneider, K. J., Tantam, D., and du Plock, S. (2019). The Wiley World Handbook of Existential Therapy.

Wallace, C. L., Wladkowski, S. P., Gibson, A., and White, P. (2020). Grief during the COVID-19 pandemic: considerations for palliative care providers. Journal of pain and symptom management, 60(1), 70-76.

Wilsey, S. A., and Shear, M. K. (2007). Descriptions of social support in treatment narratives of complicated grievers. Death Studies, 31(9), 801-819.

Worden, J. W. (2018). Grief counseling and grief therapy: A handbook for the mental health practitioner. Springer publishing Company.

Wortman, C. B., and Silver, R. C. (1989). The myths of coping with loss. Journal of consulting and clinical psychology, 57(3), 349.

Yörük, S., Türkmen, H., Yalnız, H., ve Nebioğlu, M. (2016). Gebelikte yas, kayıp ve ebelik. [Grief, loss and midwifery in pregnancy]. Düzce Üniversitesi Sağlık Bilimleri Enstitüsü Dergisi, 6(3), 207-212.