

KLİNİK PSİKOLOJİ ALANINDA AKADEMİK TARTIŞMALAR

Editör: Dr.Öğr.Üyesi Begüm AÇIKYAVUZ

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yayınları

Klinik Psikoloji Alanında Akademik Tartışmalar

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Ayşe Hazal DÜNDAR

"Bu kitapta yer alan bölümlerde kullanılan kaynakların, görüşlerin, bulguların, sonuçların, tablo, şekil, resim ve her türlü içeriğin sorumluluğu yazar veya yazarlarına ait olup ulusal ve uluslararası telif haklarına konu olabilecek mali ve hukuki sorumluluk da yazarlara aittir."

ERKEN ÇOCUKLUK DÖNEMİNDE GELİŞİMSEL FARKLILIKLAR VE ERKEN MÜDAHALE: KURAMSAL TEMELLER, RİSK GÖSTERGELERİ VE TÜRKİYE UYGULAMALARINA DAİR BİR İNCELEME

Begüm AÇIK YAVUZ¹

1. GİRİŞ

Çocuk gelişimi, bireyin doğumdan itibaren biyolojik, psikolojik, bilişsel, sosyal ve duygusal alanlarda ilerlemesini kapsayan dinamik bir süreçtir (Santrock, 2020). Bu süreçte bazı çocuklar gelişimsel normların dışında kalabilmekte ve destek ihtiyacı doğabilmektedir. Normal dağılım eğrisi dikkate alındığında, ortalamanın dışında kalan çocuklar özel ilgi gerektirir (Berk, 2018). Gelişimsel dağılımda çocuklar genellikle ortalama etrafında yoğunlaşırken, gelişimsel gecikme yaşayan ve üstün yetenekli çocuklar eğrinin uçlarında yer alır. Çocuk gelişimi çoğu zaman istatistiksel olarak normal dağılım (çan eğrisi) modeli ile açıklanmaktadır (Kail & Cavanaugh, 2019).

Bu modele göre çocukların büyük bir çoğunluğu gelişimsel açıdan ortalama düzeyde yer alırken, daha küçük bir grup ortalamanın altında ya da üstünde konumlanmaktadır. Çan eğrisinin dışında kalan bu çocuklar, gelişimsel açıdan “risk altında” ya da “farklı gelişim gösteren” gruplar olarak değerlendirilmektedir (WHO, 2012).

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Çan eğrisinin alt ucunda yer alan çocuklar; gelişimsel gecikme, zihinsel yetersizlik, otizm spektrum bozukluğu, dil ve konuşma bozuklukları ya da dikkat eksikliği gibi nedenlerle yaşlılarına kıyasla daha yavaş ilerleme gösteren çocuklardır (APA, 2013). Bu gruptaki çocuklar genellikle öğrenme fırsatlarından yeterince yararlanmakta zorlanmakta ve desteklenmedikleri takdirde gelişimsel fark zamanla daha da belirgin hale gelebilmektedir (Shonkoff & Phillips, 2000). Bu nedenle erken müdahale bu grup için kritik öneme sahiptir.

Öte yandan çan eğrisinin üst ucunda yer alan çocuklar ise üstün yetenekli veya ileri gelişim gösteren çocuklardır. Bu çocuklar bilişsel, dilsel ya da yaratıcılık alanlarında yaşlılarının üzerinde performans sergileyebilirler (Winner, 1996). Ancak bu durum her zaman sorunsuz bir gelişim anlamına gelmemekte; uygun şekilde desteklenmediklerinde motivasyon kaybı, sosyal uyum güçlükleri veya potansiyellerinin altında performans gösterme gibi riskler ortaya çıkabilmektedir (Renzulli, 2012).

Her iki uçta yer alan çocukların ortak özelliği, standart eğitim ve gelişim ortamlarının ihtiyaçlarını tam olarak karşılayamamasıdır. Bu nedenle bu çocuklar için bireyselleştirilmiş, esnek ve gelişimsel özelliklerine duyarlı müdahale programlarının oluşturulması gerekmektedir (Tomlinson, 2014). Erken müdahale yaklaşımları, yalnızca gelişimsel gecikme yaşayan çocuklar için değil, aynı zamanda gelişimsel olarak ileri düzeyde olan çocukların potansiyellerinin desteklenmesi açısından da önemli bir rol oynamaktadır (Guralnick, 2011).

Sonuç olarak, çan eğrisinin dışında kalan çocuklar gelişimsel çeşitliliğin önemli bir parçasını oluşturmaktadır. Bu çocukların erken dönemde doğru şekilde fark edilmesi ve uygun müdahalelerle desteklenmesi, hem bireysel gelişimlerinin en üst

düzeğe çıkarılması hem de eğitim sisteminin kapsayıcılığının artırılması açısından büyük önem taşımaktadır.

2. ERKEN MÜDAHALENİN TANIMI VE KURAMSAL TEMELLERİ

Erken müdahale, gelişimsel farklılık gösteren çocukların yaşam kalitesini artırmak, gelişimsel riskleri azaltmak ve bireysel potansiyellerini en üst düzeye çıkarmak amacıyla uygulanan sistematik ve bütüncül destek süreçlerini ifade etmektedir (Guralnick, 2011). Bu bağlamda erken müdahale; 0–6 yaş arası çocuklarda gelişimsel gecikme, risk ya da yetersizlik durumlarında, çocuğı ve ailesini kapsayan, disiplinlerarası iş birliğine dayalı yapılandırılmış hizmetler bütünü olarak tanımlanmaktadır (Shonkoff & Phillips, 2000). Bu hizmetler; gelişimsel değerlendirme, bireyselleştirilmiş eğitim destekleri, aile danışmanlığı ve sağlık hizmetleri gibi çok boyutlu bileşenleri içermekte olup, çocuğun bilişsel, psikolojik, dil, motor, sosyal ve duygusal gelişim alanlarını bütüncül bir yaklaşımla ele almaktadır (WHO, 2012).

Erken müdahalenin kuramsal temelleri, büyük ölçüde nörogelişimsel yaklaşımlar ve beyin plastisitesi kavramına dayanmaktadır (Kolb & Gibb, 2011). Yaşamın ilk yıllarında beynin yüksek düzeyde plastisite göstermesi, çevresel uyaranlara ve deneyimlere karşı duyarlılığı artırmakta; bu durum erken müdahalelerin etkisini güçlendirmektedir (Center on the Developing Child, 2007). Özellikle 0–3 yaş arası dönem, sinaptik bağlantıların hızla kurulduğu ve yeniden yapılandığı bir süreç olarak kritik bir gelişimsel pencereyi temsil etmektedir (Shonkoff & Phillips, 2000). Bu nedenle erken dönemde sunulan uygun müdahaleler, yalnızca mevcut gelişimsel gecikmeleri azaltmakla kalmamakta, aynı zamanda gelişimsel seyrin yeniden şekillendirilmesine olanak tanımaktadır.

Bununla birlikte erken çocukluk dönemi, yalnızca yüksek plastisite ile değil, aynı zamanda tanısız belirsizliklerle de karakterize edilmektedir (Glascoe & Marks, 2011). Klinik uygulamada sıklıkla kullanılan Küresel Gelişimsel Gecikme (GDD) ve Karma Spesifik Gelişimsel Bozukluk (MSDD) gibi tanımlamalar, bu belirsizliğin yönetilmesine yönelik işlevsel kategoriler sunmaktadır (APA, 2013). GDD, genellikle 5 yaş altı çocuklarda en az iki gelişim alanında belirgin gecikme olduğunda kullanılan geçici bir tanı olarak değerlendirilirken; MSDD, küresel bir gerilikten ziyade birden fazla gelişim alanında heterojen zorlukların varlığını ifade etmektedir (WHO, 2012). Bu tanı kategorileri, kesin sınıflamalardan ziyade çocuğun gelişimsel risk profilini tanımlayan ve izlem gereksinimini ortaya koyan dinamik yapılar olarak ele alınmaktadır.

Kuramsal açıdan erken müdahale, pasif bir izleme yaklaşımından ziyade aktif ve yapılandırıcı bir müdahale anlayışını gerektirmektedir (Guralnick, 2011). Geleneksel olarak benimsenen “bekle-gör” yaklaşımı, özellikle yüksek risk grubundaki çocuklarda gelişimsel fırsatların kaçırılmasına neden olabilmektedir (Dawson et al., 2010). Oysa erken müdahale paradigmaları, çocuğun gelişimsel sürecine erken dönemde müdahil olunmasını ve çevresel uyaranların bilinçli biçimde yapılandırılmasını savunmaktadır. Bu bağlamda klinisyenler yalnızca değerlendirme yapan uzmanlar değil, aynı zamanda çocuğun gelişimsel potansiyelini destekleyen ve yönlendiren aktif aktörler olarak konumlandırılmaktadır.

Erken müdahalenin kuramsal çerçevesinde bir diğer önemli boyut, gelişimin boylamsal olarak izlenmesi ve risk göstergelerinin erken dönemde tanımlanmasıdır (Sameroff, 2009). Tek zamanlı değerlendirmeler çoğu zaman sınırlı bilgi sunarken, çocuğun gelişimsel seyrinin zaman içinde izlenmesi, ortaya çıkan değişimlerin ve olası risklerin daha doğru yorumlanmasına olanak tanımaktadır. Bu süreçte dikkat

becerileri, uyumsuz işlevsellik ve erken psikopatolojik belirtiler gibi göstergeler, gelişimsel sonuçların öngörülmesinde önemli ipuçları sunmaktadır (Achenbach & Rescorla, 2000). Bu çok boyutlu değerlendirme yaklaşımı, müdahale programlarının bireyselleştirilmesini ve daha etkili hale getirilmesini sağlamaktadır.

Sonuç olarak, erken müdahalenin kuramsal temeli; beyin plastisitesi, gelişimsel riskin erken belirlenmesi, tanısal belirsizliğin dinamik olarak yönetilmesi ve aktif müdahale ilkeleri üzerine inşa edilmektedir. Bu çerçevede, erken çocukluk döneminde sunulan müdahalelerin yalnızca destekleyici değil, aynı zamanda gelişimsel süreci dönüştürücü bir işlev üstlenmesini mümkün kılmaktadır.

3. ERKEN DÖNEMDE RİSK GÖSTERGELERİ VE DEĞERLENDİRME

Erken çocukluk döneminde zihinsel yetersizlik (Intellectual Disability; ID) riskinin öngörülmesi, yalnızca tanılama açısından değil, aynı zamanda müdahalenin zamanlaması, yoğunluğu ve içeriğinin belirlenmesi açısından kritik bir öneme sahiptir (Schalock et al., 2010). Bu nedenle erken müdahalenin etkili olabilmesi için erken tanılama süreci temel bir basamak olarak değerlendirilmektedir (Guralnick, 2011). Erken tanılama kapsamında gelişim tarama testleri, sistematik klinik gözlemler ve aile görüşmeleri birlikte kullanılarak çocuğun gelişimsel profili çok boyutlu bir biçimde ortaya konulmaktadır (Glascoe & Marks, 2011). Bu bütüncül değerlendirme yaklaşımı, çocuğun güçlü ve desteklenmesi gereken yönlerinin belirlenmesine olanak tanımakta ve bireyselleştirilmiş müdahale programlarının planlanmasını mümkün kılmaktadır.

Bu bağlamda gelişimsel gecikme gösteren çocukların erken dönemde ayrıntılı biçimde değerlendirilmesi, ilerleyen

süreçte ortaya çıkabilecek bilişsel sınırlılıkların önlenmesi ya da etkilerinin azaltılması açısından belirleyici olmaktadır (APA, 2013). Özellikle dikkat becerilerindeki erken dönem yetersizlikler, çoğu zaman ikincil bir belirti olarak görülse de, öğrenme süreçleri üzerinde merkezi bir rol oynamaktadır (Posner & Rothbart, 2007). Dikkatini sürdüremeyen çocuk, çevresel uyaranlardan yeterince yararlanamamakta ve bu durum öğrenme fırsatlarının azalmasına yol açarak gelişimsel gecikmenin derinleşmesine neden olmaktadır. Bu süreç kümülatif bir etki yaratarak zamanla bilişsel gelişimde daha belirgin sınırlılıklara ve ilerleyen dönemlerde ID tanısının kesinleşmesine zemin hazırlayabilmektedir (Alloway et al., 2009). Nitekim güncel bulgular, GDD tanısı alan çocuklarda dikkat sorunlarının daha yüksek düzeyde görülebildiğini ve bunun önemli bir risk göstergesi olduğunu ortaya koymaktadır (Sperandini, 2026).

Bununla birlikte uyumsal işlevsellik (adaptive functioning), erken dönemde izlenmesi gereken bir diğer kritik alanı oluşturmaktadır (Schalock et al., 2010). Kavramsal, sosyal ve pratik alanları kapsayan uyumsal beceriler, çocuğun günlük yaşamda bağımsız işlev görebilme kapasitesini yansıtmaktadır (Tassé et al., 2012). Özellikle kavramsal alan; iletişim, öz düzenleme ve akademik hazırlık gibi bileşenleri içermesi nedeniyle bilişsel kapasite ile en güçlü ilişkiyi gösteren alan olarak öne çıkmakta ve zihinsel yetersizlik riskini öngörmede önemli bir belirleyici olarak kabul edilmektedir.

Erken dönemde psikopatolojik belirtilerin izlenmesi de değerlendirme sürecinin ayrılmaz bir parçasıdır (Achenbach & Rescorla, 2000). Başlangıçta klinik eşik altında kalan karşıt olma-karşı gelme davranışları, agresyon ve anksiyete gibi belirtiler, zaman içinde daha belirgin hale gelerek gelişimsel risk profilini ağırlaştırabilmektedir (Egger & Angold, 2006). Bu tür semptomlar çoğu zaman bilişsel sınırlılıklar ve uyumsal güçlüklerin bir dışavurumu olarak ortaya çıkmakta; dolayısıyla

erken dönemde fark edilip ele alınmaları, hem davranışsal sorunların kronikleşmesini önlemek hem de çocuğun genel gelişimsel işlevselliğini desteklemek açısından önem taşımaktadır.

Sonuç olarak, erken müdahale süreçlerinde yalnızca gelişimsel gecikmenin varlığına odaklanmak yeterli değildir. Etkili bir müdahale için erken tanılama süreçleriyle desteklenen; dikkat becerileri, uyumsal işlevsellik ve psikopatolojik belirtileri kapsayan çok boyutlu bir değerlendirme yaklaşımının benimsenmesi gerekmektedir (Sameroff, 2009). Bu bütüncül yaklaşım, zihinsel yetersizlik riskinin daha erken ve doğru biçimde öngörülmesini sağlayarak müdahale programlarının daha hedefe yönelik ve etkili şekilde planlanmasına olanak tanımaktadır.

4. DİSİPLİNERARASI YAKLAŞIM

Erken müdahale hizmetleri doğası gereği çok disiplinli bir yapı göstermekte olup, tek bir uzmanlık alanının sınırları içinde ele alınması yeterli olmamaktadır (Guralnick, 2011). Bu süreçte psikologlar, özel eğitim uzmanları, dil ve konuşma terapistleri, fizyoterapistler ile çocuk gelişimciler iş birliği içinde çalışarak çocuğun gereksinimlerini çok yönlü bir bakış açısıyla değerlendirmektedir (King et al., 2009). Disiplinlerarası bu yaklaşım, yalnızca belirli bir gelişim alanına odaklanmak yerine psikolojik, bilişsel, dil, motor, sosyal ve duygusal gelişimin eş zamanlı olarak desteklenmesini mümkün kılmaktadır (Shonkoff & Phillips, 2000). Böylece çocuğun bireysel farklılıkları dikkate alınarak bütüncül ve etkili müdahale programları oluşturulabilmektedir.

Tüm uzmanlar için bir eylem planı düşünüldüğünde erken müdahale süreçlerinde zamanlama kritik bir belirleyicidir; gelişimsel gecikmelerin “zamanla düzelir” anlayışıyla

ertelenmesi, beynin yüksek plastisite gösterdiği erken dönem fırsatlarının kaçırılmasına yol açabilmektedir (Center on the Developing Child, 2007). Bu nedenle müdahalelerin, gelişimsel pencereler kapanmadan önce yapılandırılmış desteklerle başlatılması büyük önem taşır (Vygotsky, 1978). Sürecin etkililiğinin sağlanabilmesi için değerlendirme ve izleme aşamalarında sezgisel yaklaşımlar yerine geçerliği ve güvenilirliği kanıtlanmış standart ölçme araçlarının kullanılması gereklidir (Glascoe & Marks, 2011). Bu bağlamda *Bayley Scales of Infant and Toddler Development*, *Griffiths Mental Development Scales* ve *Wechsler Intelligence Scale for Children-IV* gibi değerlendirme araçları bilimsel temelli karar alma süreçlerini desteklemektedir (Bayley, 2006; Griffiths, 2006; Wechsler, 2003).

Bununla birlikte, erken müdahalenin başarısı yalnızca uzman merkezli uygulamalarla sınırlı kalmamakta; aksine, aile katılımının sağlandığı ve müdahalenin doğal yaşam ortamlarına entegre edildiği durumlarda daha kalıcı ve etkili sonuçlar elde edilmektedir (Dunst, Bruder, & Espe-Sherwindt, 2014). Ailenin sürece aktif olarak dahil edilmesi, çocuğun günlük yaşam deneyimlerinin gelişimsel fırsatlara dönüştürülmesini mümkün kılmakta ve müdahalenin sürdürülebilirliğini artırmaktadır (McWilliam, 2010).

5. AİLE KATILIMI VE AİLE MERKEZLİ MÜDAHALE

Erken müdahale programlarının etkililiğinde ailelerin aktif katılımı merkezi bir rol oynamaktadır (Dunst & Espe-Sherwindt, 2016). Çocuğun gelişimi yalnızca uzmanlar tarafından sunulan yapılandırılmış oturumlarla sınırlı olmayıp, büyük ölçüde çocuğun içinde bulunduğu doğal yaşam bağlamı tarafından şekillenmektedir (Bronfenbrenner, 1979). Bu bağlamda aile,

çocuğun ilk ve en sürekli öğrenme ortamını oluşturarak gelişimsel süreçlerin temel belirleyicilerinden biri haline gelmektedir. Günlük yaşam rutinleri—beslenme, oyun, iletişim kurma ve bakım verme gibi etkileşimler—uygun şekilde yapılandırıldığında önemli öğrenme fırsatlarına dönüşebilmektedir (McWilliam, 2010). Güncel araştırmalar, aile merkezli yaklaşımların çocuk ve aile katılımını artırdığını, ebeveyn öz-yeterliliğini güçlendirdiğini ve yaşam kalitesini olumlu yönde etkilediğini ortaya koymaktadır (Dunst, Bruder, & Espe-Sherwindt, 2014).

Ailelerin erken müdahale sürecine aktif olarak dahil edilmesi, yalnızca çocuğun gelişimsel kazanımlarını artırmakla kalmamakta, aynı zamanda öğrenilen becerilerin farklı ortamlara genellenmesini ve kalıcılığını da güçlendirmektedir (Mahoney & Perales, 2003). Özellikle aile merkezli uygulamaların, çocukların günlük rutinlerine entegre edilmesiyle müdahalenin sürekliliği sağlanmakta ve daha sürdürülebilir sonuçlar elde edilmektedir (McWilliam, 2010). Bununla birlikte, aile ile uzmanlar arasında kurulan iş birliğine dayalı ilişki; saygı, ortak karar alma ve karşılıklı etkileşim gibi temel ilkeler üzerine inşa edilmekte olup, bu durum müdahalenin niteliğini doğrudan etkilemektedir (Turnbull et al., 2015).

Ayrıca aile katılımı, ebeveynlerin çocuklarının gelişimsel özelliklerini daha iyi anlamalarına ve ihtiyaçlarına uygun tepkiler geliştirmelerine olanak tanımaktadır. Bu süreç, ebeveyn-çocuk etkileşiminin niteliğini artırarak sosyal-duygusal gelişimi desteklemekte ve aile işlevselliğini güçlendirmektedir (Sameroff, 2009). Güncel çalışmalar, aile merkezli erken müdahale yaklaşımlarının yalnızca çocuk gelişimi üzerinde değil, aynı zamanda ebeveynlerin psikososyal iyi oluşu ve aile yaşam kalitesi üzerinde de anlamlı etkiler yarattığını göstermektedir (Dunst & Espe-Sherwindt, 2016).

Sonuç olarak, çağdaş erken müdahale yaklaşımlarında aile yalnızca desteklenen bir unsur değil, müdahalenin aktif ve vazgeçilmez bir bileşeni olarak konumlandırılmaktadır. Bu nedenle etkili bir erken müdahale programı, çocuğa sunulan hizmetlerle sınırlı kalmayıp, aileyi güçlendiren, doğal yaşam ortamlarını temel alan ve iş birliğine dayalı bir yapı içerisinde tasarlanmalıdır.

6. TÜRKİYE'DE ERKEN MÜDAHALE UYGULAMALARI

Erken müdahale hizmetleri, çocuğun gelişimsel ihtiyaçlarına en uygun şekilde yanıt verebilmek amacıyla farklı ortamlarda sunulabilmektedir (Shonkoff & Phillips, 2000). Bu hizmetler ev temelli programlar, okul öncesi eğitim kurumları, hastaneler ve rehabilitasyon merkezleri gibi çeşitli bağlamlarda yürütülmektedir (Guralnick, 2011). Özellikle ev temelli uygulamalar, müdahalenin çocuğun doğal yaşam ortamına entegre edilmesini sağlayarak öğrenmenin günlük rutinler içinde gerçekleşmesine olanak tanımaktadır (McWilliam, 2010). Okul öncesi kurumlar akran etkileşimi ve yapılandırılmış öğrenme deneyimleri açısından önemli fırsatlar sunarken, sağlık ve rehabilitasyon merkezleri daha yoğun ve uzmanlık gerektiren desteklerin sağlandığı ortamlar olarak öne çıkmaktadır.

Bu temel hizmet alanlarının yanı sıra, erken müdahalenin erişilebilirliğini ve kapsayıcılığını artırmaya yönelik yenilikçi uygulamalar da giderek yaygınlaşmaktadır. Bu bağlamda gezici anaokulu uygulamaları, özellikle dezavantajlı ve kırsal bölgelerde yaşayan çocukların erken çocukluk eğitimine erişimini artırmayı hedefleyen önemli bir model olarak dikkat çekmektedir (UNICEF, 2019). Bu tür uygulamalar, erken müdahale hizmetlerinin mekânsal sınırlılıklarını azaltarak daha geniş bir çocuk grubuna ulaşılmasını sağlamaktadır.

Bununla birlikte son yıllarda öne çıkan yaklaşımlardan biri olan Neuroplay Yaklaşımı, nörobilim temelli oyun uygulamalarını merkeze alarak çocuğun dikkat, öz düzenleme ve sosyal etkileşim becerilerini desteklemeyi amaçlamaktadır (Diamond, 2013). Oyun temelli müdahalelerin beyin plastisitesi üzerindeki olumlu etkileri göz önünde bulundurulduğunda, bu tür yaklaşımlar erken müdahale süreçlerinde önemli bir yer tutmaktadır.

Ayrıca erken çocukluk dönemine yönelik alternatif öğrenme alanları da giderek önem kazanmaktadır. Bu bağlamda bebek ve çocuk kütüphaneleri, erken okuryazarlık becerilerinin desteklenmesi, dil gelişiminin teşvik edilmesi ve çocuk-aile etkileşiminin zenginleştirilmesi açısından önemli bir destek alanı olarak değerlendirilmektedir (IFLA, 2018). Kütüphane temelli programlar, çocuklara zengin uyaranlar sunarken ebeveynlere de rehberlik sağlayarak aile katılımını güçlendirmektedir.

Türkiye’de erken müdahale alanında geliştirilen önemli programlardan biri de ETEÇOM’dur (Erken Etkileşim Temelli Çocukluk Müdahale Programı). ETEÇOM, erken çocukluk döneminde gelişimsel risk taşıyan çocukların sosyal iletişim, etkileşim ve dil becerilerini desteklemeyi amaçlayan, bilimsel temellere dayalı bir müdahale programıdır (Kırcaali-İftar & Akgün, 2009). Program, özellikle otizm spektrum bozukluğu ve gelişimsel gecikme riski bulunan çocuklarda erken sosyal etkileşimin güçlendirilmesine odaklanmaktadır. ETEÇOM’un temel yaklaşımı, çocuğun doğal etkileşim ortamlarında öğrenmesini destekleyen etkileşim temelli müdahale modeline dayanmaktadır. Bu modelde ebeveynler ve bakım verenler aktif birer uygulayıcı olarak sürece dahil edilmekte; böylece müdahale yalnızca uzmanla sınırlı kalmayıp çocuğun günlük yaşamına yayılmaktadır (Warren & Brady, 2007). Araştırmalar, etkileşim temelli müdahalelerin erken dönemde uygulandığında dil gelişimi, sosyal iletişim ve oyun becerileri üzerinde olumlu

etkiler yarattığını göstermektedir (Roberts & Kaiser, 2011). Sonuç olarak ETEÇOM, Türkiye’de erken müdahale alanında geliştirilen ve aile katılımını merkeze alan önemli uygulamalardan biri olarak öne çıkmaktadır.

Bu çok yönlü hizmet sunum yapısı, Türkiye’de geliştirilen erken müdahale projelerinde de kendini göstermektedir. Türkiye’de erken müdahale hizmetleri son yıllarda politika düzeyinde güçlenmekte ve sistematik bir yapıya kavuşmaktadır (Aile ve Sosyal Hizmetler Bakanlığı, 2022). Bu bağlamda en dikkat çekici girişimlerden biri, Aile Temelli Ulusal Erken Müdahale Sistemidir. Bu sistem, UNICEF teknik desteği ve ilgili kurumların iş birliğiyle geliştirilmiş olup, erken müdahalenin bütüncül ve erişilebilir bir modelle sunulmasını hedeflemektedir (UNICEF, 2020).

Bu gelişmeler doğrultusunda Türkiye’de erken müdahale hizmetlerinin yalnızca belirli kurumlarla sınırlı kalmayıp; ev, okul, toplum ve alternatif öğrenme ortamlarını kapsayan geniş bir ekosistem içerisinde yapılandırıldığı görülmektedir. Bu çeşitlilik, erken müdahalenin hem erişilebilirliğini artırmakta hem de çocuğun gelişiminin doğal bağlamlar içinde desteklenmesine olanak tanımaktadır.

7. SONUÇLAR VE ÖNERİLER

Bu derleme, erken müdahalenin gelişimsel farklılık gösteren çocukların bilişsel, dilsel, sosyal-duygusal ve uyumsal işlevsellik alanlarında uzun vadeli çıktıları belirleyen kritik bir bileşen olduğunu ortaya koymaktadır (Guralnick, 2011). Erken çocukluk döneminin nörobiyolojik temelleri dikkate alındığında, özellikle yaşamın ilk yıllarında gözlenen yüksek sinaptik plastisite, çevresel girdilere duyarlılığı artırmakta ve bu dönemi müdahale açısından benzersiz bir fırsat penceresi haline getirmektedir (Center on the Developing Child, 2007). Bu

bağlamda erken müdahale, yalnızca mevcut gelişimsel gecikmeleri telafi etmeye yönelik bir uygulama değil; gelişimsel yörüngeyi yeniden şekillendirme potansiyeline sahip, önleyici ve dönüştürücü bir süreç olarak değerlendirilmelidir (Shonkoff & Phillips, 2000).

Bununla birlikte erken müdahalenin etkililiği, müdahalenin zamanında başlatılması, bilimsel temellere dayalı olarak yapılandırılması ve bireyselleştirilmiş bir yaklaşımla uygulanması ile doğrudan ilişkilidir (Sameroff, 2009). Tanısal belirsizliğin yüksek olduğu erken çocukluk döneminde, GDD ve MSDD gibi geçici tanı kategorileri klinik karar verme süreçlerinde işlevsel bir çerçeve sunmaktadır (APA, 2013). Ancak bu kategorilerin statik değil, gelişimsel olarak değişken yapılar olduğu göz önünde bulundurulmalı; değerlendirme süreçleri boylamsal veriyle desteklenmelidir (Glascoe & Marks, 2011). Bu noktada dikkat becerileri, uyumsal işlevsellik ve erken psikopatolojik belirtiler gibi çok boyutlu risk göstergelerinin sistematik biçimde izlenmesi, zihinsel yetersizlik gibi daha kalıcı gelişimsel sonuçların öngörülmesinde kritik bir rol oynamaktadır (Achenbach & Rescorla, 2000).

Erken müdahale süreçlerinde aile katılımı, yalnızca destekleyici bir unsur değil, müdahalenin etkililiğini belirleyen temel bir bileşen olarak ele alınmalıdır (Dunst & Espe-Sherwindt, 2016). Aile merkezli yaklaşımlar, çocuğun öğrenme fırsatlarını doğal yaşam bağlamına yayarak müdahalenin sürekliliğini ve genellenebilirliğini artırmaktadır (McWilliam, 2010). Bu durum, yalnızca çocuğun gelişimsel kazanımlarını güçlendirmekle kalmamakta, aynı zamanda ebeveynlerin öz-yeterlik algısını artırarak aile sisteminin genel işlevselliğine de katkı sağlamaktadır (Sameroff, 2009). Dolayısıyla erken müdahale modellerinin, aileyi pasif bir alıcı konumundan çıkararak aktif bir uygulayıcı ve karar verici olarak konumlandırması gerekmektedir.

Hizmet sunum modelleri açısından değerlendirildiğinde, erken müdahalenin tek bir kurumsal yapı ile sınırlı kalmaması; ev temelli programlar, okul öncesi kurumlar, sağlık ve rehabilitasyon hizmetleri ile birlikte toplum temelli uygulamaları kapsayan çok katmanlı bir sistem içerisinde ele alınması gerekmektedir (Guralnick, 2011). Gezici anaokulu uygulamaları, oyun temelli yaklaşımlar ve çocuk kütüphaneleri gibi alternatif modeller, özellikle dezavantajlı gruplar için erişilebilirliği artırmakta ve müdahalenin doğal bağlamlara entegrasyonunu güçlendirmektedir (UNICEF, 2019). Bu çeşitlilik, erken müdahalenin yalnızca klinik bir hizmet olmaktan çıkarak toplumsal bir destek mekanizmasına dönüşmesini sağlamaktadır.

Türkiye bağlamında değerlendirildiğinde, Aile ve Sosyal Hizmetler Bakanlığı koordinasyonunda yürütülen ulusal erken müdahale girişimleri ve UNICEF iş birlikleri, hizmetlerin bütüncül bir sistem çerçevesinde yapılandırılmasına yönelik önemli adımlar olarak öne çıkmaktadır (Aile ve Sosyal Hizmetler Bakanlığı, 2022; UNICEF, 2020). Bunun yanı sıra ETEÇOM gibi etkileşim temelli ve aile merkezli programlar, uygulama düzeyinde nitelikli örnekler sunmaktadır (Kırcaali-İftar & Akgün, 2009). Ancak bu girişimlerin sürdürülebilirliği, ülke geneline yaygınlaştırılması ve standartlaştırılması için politika, eğitim ve araştırma boyutlarının eş zamanlı olarak güçlendirilmesi gerekmektedir.

Sonuç olarak erken müdahale, gelişimsel farklılıkların yönetiminde reaktif bir yaklaşımın ötesine geçerek proaktif, önleyici ve sistem temelli bir paradigma gerektirmektedir (Guralnick, 2011). Bu doğrultuda; (i) erken tanılama sistemlerinin yaygınlaştırılması ve standardizasyonu, (ii) disiplinlerarası iş birliğinin kurumsallaştırılması, (iii) aile merkezli uygulamaların güçlendirilmesi, (iv) hizmetlerin farklı bağlamlarda erişilebilirliğinin artırılması ve (v) boylamsal, kanıta dayalı araştırmaların desteklenmesi temel öncelikler olarak öne

çıkacaktır. Gelecek arařtırmaların, erken müdahale programlarının uzun vadeli etkilerini, kültürel bağlama duyarlılığını ve maliyet-etkililiğini inceleyen bütüncül modeller geliřtirmeye odaklanması, alanın kuramsal ve uygulamalı gelişimine önemli katkıları sağlayacaktır.

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TRAUMATIC LOSS IN COUPLE RELATIONSHIPS: A PSYCHODYNAMIC AND RELATIONAL CLINICAL FORMULATION PERSPECTIVE

Ezel AVCI¹

1. INTRODUCTION

Traumatic loss is conceptualized as a multidimensional clinical condition associated with the death of a loved one under sudden, violent, or life-threatening circumstances. Events such as natural disasters, war, suicide, homicide, and unexpected deaths involve not only the experience of bereavement but also exposure to intense fear, helplessness, and perceived threat. Consequently, traumatic loss is understood not merely as a grief reaction following death, but as a phenomenon situated at the intersection of trauma, attachment, and psychological reorganization (Jann et al., 2024; Killikelly et al., 2025).

Contemporary research indicates that when a traumatic event and the loss of a loved one occur simultaneously, symptoms of posttraumatic stress and prolonged or complicated grief frequently co-occur (Jann et al., 2024; Janshen et al., 2025). Grief-related manifestations, including intense yearning, persistent preoccupation with the deceased, and functional impairment, may be accompanied by trauma-related symptoms such as intrusive recollections, avoidance behaviors, hypervigilance, and guilt (Prigerson et al., 2009; Jann et al., 2024; Killikelly et al., 2025). Accordingly, the assessment of traumatic

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loss requires consideration of the circumstances of the death, the nature of the relationship with the deceased, attachment patterns, and available social support systems (Eisma et al., 2023).

The clinical psychology literature suggests that although Prolonged Grief Disorder (PGD) shares certain features with major depressive disorder and posttraumatic stress disorder (PTSD), it constitutes a distinct clinical syndrome with its own characteristic symptom profile. Current discussions within the DSM-5-TR and ICD-11 frameworks continue to emphasize the diagnostic relevance and clinical distinctiveness of PGD (Eisma, 2023; Killikelly et al., 2025). In addition, grief-focused psychotherapeutic interventions have been shown to be effective in reducing symptoms of prolonged and complicated grief (Hao et al., 2024).

From a psychodynamic perspective, conscious and unconscious bonds with the deceased, internal object representations, and processes involving guilt, anger, and ambivalence are considered central to understanding the grieving process (Bishop & Lane, 2003; Rubin, 1999). Within this framework, loss is viewed not merely as an external death event but as a process through which the individual's internal relationship with the deceased is reorganized and integrated into ongoing psychological functioning.

When examined within the context of couple relationships, traumatic loss extends beyond individual symptomatology and encompasses patterns of mutual support, emotional intimacy, and relational functioning. Studies involving bereaved parents and individuals who have experienced partner loss indicate that relationship quality, perceived similarity in grief experiences, social support, and patterns of emotional closeness are associated with both grief-related symptoms and relationship satisfaction (Buyukcan-Tetik et al., 2017; LeRoy et al., 2020;

Purrington, 2023). These findings highlight the importance of understanding traumatic loss through individual, relational, and psychodynamic dimensions simultaneously.

2. CONCEPTUAL AND THEORETICAL FOUNDATIONS

This section consolidates the conceptual, psychodynamic, and attachment-based foundations of traumatic loss. Presenting these elements together provides a more coherent basis for the later discussion of couple relationships, clinical assessment, and case formulation.

2.1. Traumatic Loss and Prolonged Grief

Grief is generally understood as a natural, multidimensional, and fluctuating process of adaptation following the death of a significant other. Bereaved individuals may experience a wide range of emotional reactions, including sadness, yearning, anger, guilt, confusion, and a search for meaning. However, intense grief does not necessarily indicate psychopathology. Prolonged Grief Disorder (PGD) is characterized by persistent difficulties accepting and integrating the reality of the loss, enduring yearning and preoccupation with the deceased, and significant impairment in daily functioning despite the passage of time (Killikelly et al., 2025). Although individuals may cognitively acknowledge the death, they may continue to struggle with its emotional integration, often displaying avoidance of loss-related reminders or recurrent preoccupation with the loss (Prigerson et al., 2009).

Traumatic loss constitutes an important risk context for the development of PGD. When death occurs under sudden, violent, or life-threatening circumstances, grief-related distress may be accompanied by symptoms associated with posttraumatic

stress (Jann et al., 2024). Deaths resulting from suicide, homicide, severe accidents, natural disasters, or war have been associated with trauma-related manifestations, including intrusive recollections, avoidance behaviors, hypervigilance, and persistent guilt (Jann et al., 2024; Janshen et al., 2025). From a psychodynamic perspective, traumatic loss is understood not only in terms of the impact of the external event itself but also in terms of its effects on the individual's internal object world and representational system (Blum, 2003). Consequently, the assessment of traumatic loss encompasses the circumstances of the death, the nature of the relationship with the deceased, attachment patterns, social support resources, and emotion-regulation processes (Eisma et al., 2023).

Symptoms of PGD frequently co-occur with depressive and posttraumatic stress symptoms. Nevertheless, the clinical core of PGD is characterized by persistent yearning for the deceased, ongoing preoccupation with the loss, difficulties accepting the death, disruptions in identity continuity, and a diminished sense of meaning in life (Prigerson et al., 2009; Killikelly et al., 2025). In contrast, major depressive disorder is more strongly characterized by pervasive worthlessness and loss of interest, whereas posttraumatic stress disorder (PTSD) is primarily associated with trauma-related intrusions, threat perception, and avoidance. Within PGD, the persistent search for the lost attachment figure and difficulties integrating the loss into one's ongoing psychological life are particularly salient. Contemporary grief theories emphasize that adaptation to bereavement cannot be adequately explained through notions of "letting go" or "forgetting." The Dual Process Model proposes that adaptive grieving involves an ongoing oscillation between loss-oriented and restoration-oriented coping processes (Stroebe & Schut, 1999). This framework is particularly relevant in the context of couple relationships, where partners may differ in their

coping orientations and may shift between these modes at different points throughout the grieving process. Accordingly, grief is increasingly conceptualized as a process shaped not only by individual psychological factors but also by relational dynamics and interpersonal adaptation.

2.2. Psychodynamic Perspectives: Object Loss, Ambivalence, and Defense Mechanisms

Within psychodynamic theory, grief is understood as a process through which the individual's emotional investment in a loved object is reorganized in response to the reality of death. Rather than emphasizing the complete relinquishment of the bond with the deceased, contemporary psychodynamic perspectives focus on transforming this relationship into a more flexible and symbolically representable form (Rubin, 1999). Consistent with this view, recent systematic review findings suggest that continuing bonds with the deceased may influence bereavement adjustment through memories, internalized relationship representations, identity processes, meaning-making, and spirituality (Hewson et al., 2024). Psychodynamic formulations, therefore, attend to internal object representations, identifications, unresolved conflicts, ambivalent emotions, and transference processes, highlighting the relevance of regret, unexpressed anger, and unfinished relational themes in the understanding of grief (Rubin, 1999).

Ambivalence represents a central concept in psychodynamic formulations of bereavement. Psychodynamic approaches conceptualize grief as involving the coexistence of love, anger, dependency, guilt, and conflict within the relationship to the deceased (Rubin, 1999). Contemporary literature further suggests that guilt is conceptually linked to symptoms of Prolonged Grief Disorder (PGD) and constitutes an important dimension of the bereavement experience (Joa &

Newberg, 2023). Consequently, guilt and self-blame following loss are understood not merely as isolated symptoms but as expressions of the individual's ongoing internal relationship with the deceased and the ambivalent emotions embedded within that relationship (Rubin, 1999).

Psychodynamic accounts of complicated and prolonged grief have also emphasized processes of identification with the lost object, guilt, repressed anger, and the influence of earlier object relationships (Bishop & Lane, 2003). Similarly, contemporary PGD literature highlights the relevance of guilt, self-blame, identity disruption, avoidance behaviours, and functional impairment in the clinical assessment of bereavement-related difficulties (Eisma, 2023; Joa & Newberg, 2023; Szuhany et al., 2021). Within this framework, depressive symptoms, social withdrawal, and self-critical tendencies are considered in relation to broader patterns of attachment, defence mechanisms, and the individual's internalized relationship with the deceased rather than being viewed solely as direct consequences of the death itself (Bishop & Lane, 2003; Rubin, 1999).

Defense mechanisms occupy a prominent place in psychodynamic understandings of grief. Processes such as idealization, devaluation, affective isolation, and avoidance may serve to regulate intense emotional responses and ambivalence associated with the lost object (Rubin, 1999; Bishop & Lane, 2003). In cases of traumatic object loss, these defensive processes are understood within the broader context of trauma-related psychological responses and disruptions in object relations (Blum, 2003).

Rubin (1999) argued that conflict, relationship patterns, and transference processes should be considered simultaneously in psychodynamic grief therapy. From this perspective, difficulties emerging within couple relationships following loss

may be understood not only in terms of communication problems but also through the symbolic representation of the deceased within the relationship and the meanings that partners attribute to one another in the aftermath of bereavement.

2.3. Attachment, Identity Continuity, and Continuing Bonds

According to attachment theory, the death of a loved one represents the loss of an attachment figure who serves essential functions related to safety, emotional closeness, and affect regulation. Consequently, bereavement involves not only separation distress but also the reorganization of the attachment system itself (Eisma et al., 2023). Findings from a recent systematic review and meta-analysis examining the relationship between adult attachment and prolonged grief indicate that insecure attachment patterns are significantly associated with symptoms of Prolonged Grief Disorder (PGD). In particular, anxious attachment has been linked to intense yearning, separation distress, and persistent preoccupation with the deceased, whereas avoidant attachment has been associated with emotional avoidance and the suppression of grief-related affect (Eisma et al., 2023; Russ et al., 2024).

Traumatic loss may affect not only the attachment system but also an individual's sense of identity and self-continuity. Diagnostic descriptions of PGD emphasize features such as identity disruption, diminished meaning in life, and impaired functioning, highlighting the clinical significance of changes in self-experience following bereavement (Prigerson et al., 2009; Eisma, 2023; Killikelly et al., 2025). Bereavement may therefore involve challenges in maintaining future-oriented goals, reconstructing social roles, and reinvesting in meaningful life activities after the loss of a partner, child, or other significant family member (Killikelly et al., 2025).

Contemporary bereavement literature suggests that continuing bonds with the deceased may constitute a natural component of adaptation to loss. Memories of the deceased, symbolic connections, and internalized relationship representations are frequently described as elements of ongoing adjustment following bereavement (Hewson et al., 2024). At the same time, the clinical significance of these bonds is often considered in relation to their impact on current relationships, everyday functioning, and engagement with life. Difficulties arise when the relationship with the deceased becomes so dominant that it substantially restricts interpersonal functioning or investment in ongoing life pursuits (Hewson et al., 2024; Killikelly et al., 2025).

3. RELATIONAL CONSEQUENCES OF TRAUMATIC LOSS IN COUPLES

After the individual and theoretical foundations are established, the focus shifts to the couple relationship. Traumatic loss may alter communication, emotional closeness, dyadic coping, defensive patterns, sexuality, and shared meaning-making; therefore, these relational consequences are best considered within a single integrated section.

3.1. Relationship Satisfaction, Mutual Support, and Dyadic Coping

Prolonged grief may have significant implications for emotional intimacy, relationship satisfaction, mutual support, and shared coping processes within couple relationships. Research on parental bereavement and partner loss suggests that grief represents a life event with the potential to foster both relational closeness and interpersonal conflict. In particular, perceived similarity in grief experiences, communication patterns, and levels of social support have been associated with relationship

satisfaction among bereaved couples (Buchanan, 2023; Buyukcan-Tetik et al., 2017; Purrington, 2023).

A study of bereaved parents found that greater perceived similarity in partners' grief experiences was associated with higher levels of relationship satisfaction (Buyukcan-Tetik et al., 2017). These findings suggest that similarities and differences in grieving styles may be relevant to relationship functioning following loss. Likewise, research on spousal bereavement indicates that social support, relationship quality, and interpersonal resources are associated with psychological adjustment during the bereavement process (Purrington, 2023).

The Dual Process Model proposes that adaptive bereavement involves an ongoing oscillation between loss-oriented and restoration-oriented coping processes (Stroebe & Schut, 1999). In couple relationships, partners may engage with these coping orientations at different times, leading to distinct expressions of grief and adaptation. Such variations are particularly evident during anniversaries, birthdays, holidays, and other reminders of the loss. Research conducted following spousal and child loss further suggests that bereavement is associated not only with psychological adjustment but also with physical health, somatic symptoms, and patterns of physical intimacy (Ergun et al., 2024; LeRoy et al., 2020). Studies of widowed individuals have reported associations between relationship satisfaction and somatic symptoms following bereavement (LeRoy et al., 2020). Similarly, investigations involving bereaved parents have indicated that affectionate touch and physical intimacy may be linked to relational closeness and interpersonal adjustment after loss (Ergun et al., 2024).

Taken together, the literature indicates that the impact of prolonged grief on couple relationships extends beyond individual symptomatology and encompasses relationship

satisfaction, social support, communication patterns, dyadic coping, and physical intimacy. Contemporary bereavement research, therefore, conceptualizes grief as a relational process that unfolds within ongoing interpersonal interactions and shared meaning-making between partners (Buyukcan-Tetik et al., 2017; Purrington, 2023; Stroebe & Schut, 1999).

3.2. Defensive Processes Within Couple Dynamics: Avoidance, Idealization, Blame, and Withdrawal

Psychodynamic literature conceptualizes grief within the context of conscious and unconscious representations of the deceased, emotional conflicts, and defense mechanisms (Rubin, 1999). Following traumatic object loss, defense mechanisms have been described as psychological processes involved in regulating intense affective experiences and trauma-related arousal (Blum, 2003). Contemporary research on traumatic loss further indicates that symptoms of Prolonged Grief Disorder (PGD) and Posttraumatic Stress Disorder (PTSD) frequently co-occur, highlighting the complexity of psychological adaptation following bereavement (Jann et al., 2024; Killikelly et al., 2025).

Avoidance is among the most frequently reported features of prolonged grief. Studies have shown that avoiding people, places, objects, or conversations associated with death may be related to the persistence of grief-related distress (Prigerson et al., 2009; Szuhany et al., 2021). In the context of traumatic loss, avoidance is also recognized as a central component of posttraumatic stress responses (Jann et al., 2024). Longitudinal findings further suggest that avoidance tendencies may contribute to reciprocal associations among prolonged grief symptoms, depressive symptoms, and posttraumatic stress symptoms over time (Janshen et al., 2025).

From a psychodynamic perspective, idealization is often considered within the broader framework of ambivalence.

Following a loss, individuals may emphasize only the positive attributes of the deceased while minimizing or excluding aspects of the relationship that involved conflict, disappointment, or hostility. Psychodynamic accounts of bereavement, therefore, highlight the coexistence of love, anger, guilt, and unresolved relational conflicts in the internal representation of the deceased (Bishop & Lane, 2003; Rubin, 1999).

Guilt and self-blame are frequently reported cognitive and emotional responses following traumatic loss. Feelings of guilt may be particularly pronounced when the death is perceived as preventable or when individuals attribute personal responsibility to themselves in relation to the loss (Jann et al., 2024). Contemporary literature suggests that guilt-related processes are associated with symptoms of PGD and constitute an important dimension of clinical assessment (Joa & Newberg, 2023). In addition, self-blame, identity disruption, and functional impairment have been identified as clinically relevant features of prolonged grief reactions (Eisma, 2023; Killikelly et al., 2025).

Emotional withdrawal and restricted affective expression represent additional patterns that may emerge following traumatic bereavement. Research has demonstrated that PGD and PTSD symptoms frequently co-occur after traumatic loss and that this symptom overlap may be associated with difficulties in interpersonal functioning (Jann et al., 2024; Rueger et al., 2024). Psychodynamic perspectives similarly describe emotional withdrawal, affective constriction, and interpersonal distancing as processes that may influence post-loss adaptation and relational functioning (Blum, 2003; Rubin, 1999).

Within couple relationships, the significance of these defensive processes is closely related to how partners perceive and interpret one another's grief responses. Research involving bereaved parents has shown that greater perceived similarity in

grief experiences is associated with higher relationship satisfaction (Buyukcan-Tetik et al., 2017). Furthermore, differences in coping orientations between partners have been conceptualized within the Dual Process Model as variations in engagement with loss-oriented and restoration-oriented coping processes (Stroebe & Schut, 1999). Collectively, these findings underscore the importance of examining grief within the broader context of communication patterns, mutual support, and relationship functioning among bereaved couples (Buyukcan-Tetik et al., 2017; Purrington, 2023).

3.3. Sexuality, Intimacy, and Emotional Availability

The relationship between bereavement and sexuality has received increasing scholarly attention in recent years, although empirical research in this area remains relatively limited. Existing evidence suggests that loss may be associated with changes in sexual intimacy, emotional availability, and patterns of physical closeness between partners. In a qualitative study involving grief therapists, the nature of the loss, traumatic experiences, secondary losses, and levels of emotional intimacy were identified as factors associated with sexual intimacy following bereavement (Jones et al., 2024).

Research involving bereaved parents has demonstrated that affectionate touch and physical intimacy are associated with relational closeness following loss (Ergun et al., 2024). Similarly, changes in physical contact and sexual intimacy after bereavement appear to be related not only to individual grief responses but also to broader relational processes occurring within couple relationships (Ergun et al., 2024; Jones et al., 2024).

Changes in intimacy and sexuality have also been examined in relation to emotional availability and relationship functioning. Findings from qualitative research suggest that partners may differ in their needs for closeness and in the ways

these needs are expressed following a significant loss (Jones et al., 2024). Moreover, emotional intimacy, communication, and mutual support have been identified as important relational dimensions associated with adaptation to bereavement (Buyukcan-Tetik et al., 2017; Purrington, 2023).

From a psychodynamic perspective, bereavement may involve the reorganization of relational investments and internal relationship representations following the loss of a significant attachment figure (Bishop & Lane, 2003; Rubin, 1999). Within this framework, changes in intimacy may be understood in relation to ongoing internal bonds with the deceased, shifts in emotional investment, and broader patterns of interpersonal relating (Rubin, 1999).

Changes in intimacy and emotional availability are increasingly conceptualized within the relational dimensions of bereavement. The Dual Process Model proposes that individuals oscillate between loss- and restoration-oriented coping modes throughout the grieving process (Stroebe & Schut, 1999). Within couple relationships, partners may engage with these processes at different times, potentially contributing to variations in emotional closeness, intimacy, and relationship dynamics following loss (Buyukcan-Tetik et al., 2017; Stroebe & Schut, 1999).

4. CLINICAL ASSESSMENT AND DIFFERENTIAL EVALUATION

The relational presentation of traumatic loss should be evaluated together with individual symptoms and clinical risks. This section therefore brings together assessment domains, differential diagnosis, and couple-based evaluation under a single clinical heading.

4.1. Individual Assessment Domains

Traumatic loss and Prolonged Grief Disorder (PGD) are conceptualized as multidimensional phenomena requiring consideration of symptom severity, the circumstances surrounding the loss, functional impairment, and co-occurring psychological difficulties (Jann et al., 2024; Killikelly et al., 2025). Contemporary PGD literature identifies persistent yearning, preoccupation with the deceased, avoidance behaviors, difficulties accepting the loss, identity disruption, and impaired functioning as central components of the clinical presentation (Prigerson et al., 2009; Killikelly et al., 2025).

In cases of traumatic bereavement, characteristics of the death—including suddenness, unexpectedness, and violent circumstances—have been associated with grief-related distress. Variables such as guilt, anger, and perceived social support have also been linked to bereavement outcomes following traumatic loss (Jann et al., 2024). Furthermore, recent studies indicate that symptoms of PGD frequently co-occur with posttraumatic stress symptoms and that reciprocal associations may exist between these symptom domains (Jann et al., 2024; Janshen et al., 2025; Rueger et al., 2024). Assessment approaches commonly incorporate both self-report measures and clinical interviews, with particular attention given to symptom severity, duration, and functional impact (Prigerson et al., 2009; Killikelly et al., 2025).

The relational dimensions of bereavement have also received increasing attention within the literature. Research involving bereaved parents suggests that perceived similarity in grief experiences is associated with relationship satisfaction, while social support and relationship quality are associated with adjustment following loss (Buyukcan-Tetik et al., 2017; LeRoy et al., 2020; Purrington, 2023). These findings highlight the

relevance of interpersonal and relational processes in understanding bereavement adaptation.

4.2. Differential Assessment and Clinical Risks

Although PGD shares certain features with Major Depressive Disorder and Posttraumatic Stress Disorder (PTSD), important distinctions have been identified across these conditions. PGD is characterized primarily by persistent yearning and ongoing preoccupation with the deceased, whereas PTSD is more strongly associated with intrusive re-experiencing, threat perception, and trauma-related avoidance (Jann et al., 2024; Killikelly et al., 2025).

Recent research has further linked PGD symptoms with suicidal ideation, depressive symptoms, and functional impairment. Social withdrawal, low levels of social support, and co-occurring psychiatric symptoms have also been associated with poorer bereavement adjustment (Szuhany et al., 2021; Rueger et al., 2024; Killikelly et al., 2025).

4.3. Couple-Based Clinical Evaluation

Research on traumatic loss and prolonged grief increasingly recognizes the importance of relational processes alongside individual symptoms. Within couple relationships, bereavement has been examined in relation to communication patterns, emotional closeness and distance, perceptions of one another's grief experiences, and social support processes. Studies have shown that perceived similarity in grief experiences is associated with relationship satisfaction, whereas grief communication, emotional sharing, and mutual support are linked to relational adjustment following loss (Buyukcan-Tetik et al., 2017; Kamm & Vandenberg, 2001).

The Dual Process Model further suggests that partners may differ in their engagement with loss-oriented and restoration-

oriented coping processes across time (Stroebe & Schut, 1999). In addition, traumatic loss research has identified factors such as guilt, anger, social support, and characteristics of the death as variables associated with grief-related outcomes (Jann et al., 2024). Together, these findings situate bereavement within a broader interpersonal context that includes both individual and relational dimensions of adaptation.

5. PSYCHODYNAMIC CASE FORMULATION AT INDIVIDUAL AND RELATIONAL LEVELS

Clinical assessment becomes therapeutically meaningful when it is translated into formulation. In this chapter, formulation is understood as a bridge between symptom presentation, internal object relations, attachment patterns, and the relational organization of grief within the couple.

Psychodynamic case formulation conceptualizes grief not merely in terms of symptom presentation but also in terms of the individual's ongoing internal relationship with the deceased, attachment patterns, defense mechanisms, identity processes, and interpersonal functioning. Within this framework, bereavement is understood as a multidimensional response to the loss of a significant relational object, extending beyond the external reality of death to encompass transformations within the individual's internal world (Rubin, 1999).

Contemporary bereavement research highlights the importance of continuing bonds as a central component of adaptation to loss. Memories of the deceased, symbolic connections, identity continuity, and meaning-making processes have all been associated with post-loss adjustment (Hewson et al., 2024). Similarly, the Meaning Reconstruction approach conceptualizes bereavement as a process through which individuals revise their life narratives, reconstruct their sense of

identity, and renegotiate fundamental assumptions about themselves and the world (Gillies & Neimeyer, 2006; Neimeyer, 2019). These perspectives are broadly consistent with psychodynamic understandings of grief as involving the ongoing reorganization of internal representations and relational meanings following loss. In the context of traumatic bereavement, characteristics of the death—including suddenness, violence, and unexpectedness—have been associated with grief outcomes alongside factors such as guilt, anger, and perceived social support (Jann et al., 2024). Furthermore, symptoms of Prolonged Grief Disorder (PGD) frequently co-occur with posttraumatic stress symptoms, and reciprocal relationships between these symptom domains have been documented in longitudinal research (Jann et al., 2024; Janshen et al., 2025). Psychodynamic formulations, therefore, consider both trauma-related processes and grief-specific dynamics when conceptualizing post-loss adaptation. Attachment theory provides an additional framework for understanding individual differences in bereavement responses. Evidence from systematic reviews and meta-analyses indicates that insecure attachment patterns are associated with higher levels of prolonged grief symptoms (Eisma et al., 2023). Contemporary models of PGD further emphasize identity disruption, separation distress, and alterations in interpersonal functioning as important dimensions of the bereavement experience (Killikelly et al., 2025). Accordingly, attachment-related expectations, internal working models, and relational vulnerabilities may contribute to the ways individuals experience and respond to loss. Mentalization-based perspectives focus on the individual's capacity to understand and reflect upon their own emotional experiences and the mental representations associated with the deceased. Research involving bereaved parents suggests that mentalizing capacities are related to the narrative coherence and integration of grief experiences (Janusz et al., 2024).

At the relational level, psychodynamic formulations extend beyond the individual to consider how loss is represented within couple relationships. Partners may differ in their perceptions of one another's grief experiences, communication styles, and coping responses following bereavement. Studies involving bereaved parents have demonstrated associations between perceived similarity in grief experiences and relationship satisfaction (Buyukcan-Tetik et al., 2017). In addition, grief communication, mutual support, dyadic coping processes, and patterns of physical intimacy have been linked to relationship adjustment following loss (Albuquerque et al., 2018; Ergun et al., 2024; Kamm & Vandenberg, 2001).

5.1. Illustrative Case Formulation: The Relational Architecture Of Traumatic Grief – The Case of Selin and Murat

Traumatic Grief and Relational Collapse

Traumatic grief shakes not only the depths of the individual psyche but also the very architecture on which intimate relationships are built. This clinical picture, defined in DSM-5-TR as “prolonged grief disorder” and similarly classified in ICD-11, deeply wounds the dyadic system, particularly in cases of sudden, violent, and collective loss such as earthquakes and disasters. In this context, grief is not merely an intrapsychic process; it is the collapse of a shared “relational architecture.”

In this chapter, we examine the case of Selin, aged 40, and Murat, aged 42, whose fourteen-year marriage was profoundly shaken by a major earthquake. Through a psychodynamic lens, we integrate Bowlby’s attachment theory, Fairbairn’s object relations theory, Melanie Klein’s depressive and paranoid-schizoid positions in mourning, Bion’s container-contained model, Winnicott’s concept of the false self, Mahler’s separation-individuation process, Ogden’s concept of thirdness, and

Fonagy's mentalization approach. In doing so, we address both the individual ruins produced by grief and the couple's shared "collapsed building." The case presents an example of "symbiotic incompleteness" and "relational petrification," both of which are frequently encountered in clinical practice in Türkiye after the 2023 earthquakes.

Ethical Note: This case is a composite clinical case derived from clinical material. All identifying information has been completely altered, and confidentiality has been preserved.

I. The Psychodynamic Story of the Case: "An Identity Trapped Beneath the Rubble"

Selin and Murat were a couple known in academic circles and appeared, from the outside, to have a harmonious marriage. When they presented fourteen months after the earthquake, their marriage had turned into a silent ruin: sexual intimacy had completely disappeared, and emotional contact had become a thin and fragile layer of ice.

Timeline and Process

The first three months: During the chaotic period following the earthquake, Murat assumed the role of the "practical rescuer." He protected Selin by managing funeral arrangements, official procedures, and logistical support. Selin, meanwhile, was in a state of shock and numbness. She treated her mother's belongings as untouchable and woke at night with escalating screams.

The sixth month: Selin's mourning deepened. She constantly spoke about her mother, refused to change the place of anything in the house, and compulsively repeated religious rituals such as memorial prayers and recitations. Murat's action-oriented support began to feel insufficient. The couple's first serious conflicts emerged during this period.

The twelfth month and beyond: Emotional disconnection became permanent. Sexual intimacy dropped to zero; even sleeping together began to evoke feelings of abandonment. The silence in their home turned into an effort by two people to “erase” one another. The shadow of the deceased mother settled between two living bodies like a massive pile of rubble.

Selin was in another city at the time of the earthquake. The guilt created by her inability to reach her mother and fulfill her desire to be the “rescuer”—a role rooted in her childhood position as a parentified child—went beyond classical survivor's guilt. It represented the deep pain of “incompleteness” in an adult who had been unable to sever a symbiotic bond with her mother. The mother's sudden absence disrupted one of the main pillars of Selin's identity. This is closely related to Abraham and Torok's concepts of the “unmourned loss” and the “uninternalized object.”

Murat's background also played a critical role in this dynamic. In childhood, he had experienced his father as distant, critical, and emotionally inaccessible. This relationship, which ended with his father's early death, made “emotional insulation” Murat's primary defense. During the first months after the disaster, Murat felt somewhat “adequate” while providing practical support. However, as Selin's grief deepened, he was forced to confront his own feelings of inadequacy. The theme of the “failed rescuer” from his childhood object relations was reactivated, pushing him toward emotional petrification, or affective constriction. His retreat into a workaholic identity functioned both as an escape and as an attempt to protect his own vulnerability.

The loss of sexuality was particularly striking. Before the earthquake, the couple had a satisfying sexual life; during the

mourning process, bodily intimacy disappeared completely. This erotic withdrawal was associated, in Selin, with bodily guilt fused with the loss of the mother and, in Murat, with sexual inhibition in response to an “invasive grief.” Grief had buried the body as well.

II. Clinical Formulation: A Multidimensional Psychodynamic Analysis

Object Relations Framework and the Idealized Lost Object

For Selin, the mother was a complex figure in whom, in Fairbairn's theoretical framework, “good” and “bad” objects were intertwined. The sudden loss of the mother violently reactivated Selin’s separation-individuation process as described by Mahler. This was not a developmental opportunity; rather, it carried the risk of regression to Klein’s paranoid-schizoid position and psychotic fragmentation.

By excessively idealizing her mother, Selin repressed her own anger and the hidden hatred or ambivalence stemming from her dependence on the mother. What she was mourning was not the reality of the mother, but an artificial sense of wholeness that had been sustained by the mother’s presence and that may be understood through Winnicott’s concept of the false self. This idealization prevented transition into Klein’s depressive position of mourning and led to a melancholic internalization.

Defense Mechanisms and the Relational Vicious Cycle

Selin’s defenses: Her primary mechanism was projective identification. She projected her own helplessness, guilt, and fragmentation anxiety onto Murat and reinterpreted his silence as “indifference” and “abandonment.” This created an aggressive cycle in which Murat was positioned as Klein’s “punitive superego.”

Murat's defenses: Affective isolation, splitting, and withdrawal were dominant. Faced with the intensity of Selin's grief, he erased himself emotionally and withdrew from his competition with the shadow of the mother. This blocked access to Ogden's concept of thirdness and reproduced his early object relations with a distant father.

These reciprocal defenses created a classical relational vicious cycle: Selin's projective attack intensified Murat's petrification, while Murat's petrification fed Selin's anger and guilt.

The Crisis of Containment: Bion's Container-Contained Model

The couple's shared capacity for containment had collapsed. Selin discharged her grief into Murat as "beta elements"—raw terror, screams, and guilt—without being able to transform them into meaningful affects through alpha function. When Murat failed to metabolize this burden, he coded Selin's inner world as "toxic" and built a thick wall around himself. Their shared capacity to think was replaced by Bion's state of "-K" or minus knowledge.

Attachment and Mentalization Perspective

Selin's attachment style was predominantly preoccupied and entangled; her unresolved loss with her mother haunted her current relationship. Murat, by contrast, displayed a dismissive-avoidant pattern and protected himself by isolating affect. From Fonagy's mentalization perspective, the couple's reflective function had been severely impaired. They could no longer read one another's mental states or build a bridge of empathy. Grief had also buried their shared mental space beneath the rubble.

Countertransference and the Clinician's Position

The therapist may resonate with Selin's parentified-child role and become vulnerable to a "rescuer fantasy." Murat's petrification may evoke feelings of helplessness and inadequacy in the therapist. The clinician must recognize these dynamics and remain in a "third" position that reconstructs Bion's containing function for the couple. From the perspective of modern relational psychoanalysis, particularly the work of Mitchell and Aron, the analysis of countertransference occupies a central place in the therapeutic process.

III. Strategic Intervention Framework for the Clinician

Core therapeutic aim: To make visible the actual loss hidden behind the anger and accusations directed by the partners toward each other: the loss of access to one another, the loss of their shared mental space, and the loss of their sexual and embodied bond.

Therapeutic Process and Technical Interventions

1. Initial Phase: Trust and Safety

The first phase involves building trust, normalizing grief, and naming guilt and anger. Images of rubble and collapse are explored jointly.

2. Middle Phase: Mentalization and the Empathic Bridge

The therapist translates Selin's accusation, "Why don't you understand me?" into Murat's possible confession: "When I hear you, I am forced to face my own inadequacy." Exercises in empathic imagination are introduced. Selin's rituals are transformed into a "shared mourning ritual," such as performing a meaningful act together in memory of her mother.

3. Advanced Phase: Reconnection and Individuation

Sexuality is gradually reconstructed through bodily exercises similar to sensate focus, while remaining intertwined with grief work. A shared narrative of loss is created. Murat's feelings of inadequacy are explored in depth through transferential and countertransferential processes.

Cultural and Symbolic Integration

In Türkiye, rituals such as the mevlit and the fortieth and fifty-second-day commemorations may create additional social pressure on the couple. These rituals should be transformed from expressions of "loyalty to the mother" into "rituals of transition toward autonomy." Religious and cultural elements must be integrated with psychodynamic work.

Potential Complications and Resistances

Selin may develop a transference in which she perceives the therapist as someone "trying to replace my mother." Murat may show resistance in the form of "Why are we still talking about this?" These resistances should be regarded as some of the most productive material of the psychodynamic process.

IV. Lessons from the Case: Relational Repair in Traumatic Grief

The case of Selin and Murat shows that it is possible to reconstruct the relational architecture of traumatic grief. Like a collapsed building, the relationship can be repaired by removing the rubble, laying new foundations, and constructing a shared containing space.

The vital importance of couple therapy in post-disaster clinical practice is evident. Relationships petrified under the "shadow of grief" can come alive again only in a space where each partner can truly hold and metabolize the other's pain. This case highlights the need for longitudinal studies on couples after

earthquakes and for the development of culturally adapted psychodynamic intervention models.

Ultimately, traumatic grief is not merely the story of a loss. It is also the story of how the living hold on to one another—or fail to do so—and how they reconstruct identities that have been trapped beneath the rubble. Selin and Murat’s shared ruins remind us that the deepest wounds can heal only when they are held together.

6. INTERVENTION PRINCIPLES, THERAPEUTIC PROCESSES, AND CULTURAL SENSITIVITY

Intervention should follow from formulation rather than from symptom reduction alone. For this reason, grief-focused treatment principles, psychodynamic therapeutic processes, couple-based considerations, and cultural sensitivity are grouped together in the final main section.

Research on interventions for Prolonged Grief Disorder (PGD) indicates that grief-related symptoms constitute specific clinical targets within psychological treatment. Randomized controlled trials and contemporary meta-analytic findings suggest that grief-focused psychotherapies can contribute to reductions in prolonged grief symptoms and facilitate adaptation following loss (Shear et al., 2005; Hao et al., 2024).

Within psychodynamic approaches, therapeutic work is conceptualized in relation to the individual's ongoing internal relationship with the deceased, experiences of ambivalence, guilt, defense mechanisms, and transference processes (Rubin, 1999; Bishop & Lane, 2003). Bereavement is therefore understood not solely as a reaction to death itself but also as a process involving

the reorganization of internal object relations and relational meanings following loss (Rubin, 1999).

Research focusing on couple relationships suggests that bereavement is associated with relationship satisfaction, communication patterns, social support, physical intimacy, and perceived similarity in grief experiences (Buyukcan-Tetik et al., 2017; Albuquerque et al., 2018; Ergun et al., 2024). In addition, partners may differ in their engagement with loss- and restoration-oriented coping processes, highlighting the relational dimensions of bereavement adaptation (Stroebe & Schut, 1999).

The psychodynamic literature further emphasizes the relevance of therapeutic relationships, transference, and countertransference processes in the understanding of grief-related difficulties. Themes involving guilt, anger, dependency, and relational expectations may emerge within the therapeutic relationship and can provide valuable insights into broader patterns of adaptation following loss (Rubin, 1999; Bishop & Lane, 2003).

Cultural and religious contexts are increasingly recognized as important dimensions of bereavement experiences. Mourning rituals, help-seeking behaviors, expressions of grief, and sources of social support may vary considerably across cultural settings. Contemporary literature, therefore, highlights the importance of considering cultural, religious, and social contexts when conceptualizing traumatic loss and prolonged grief (Smid et al., 2018).

PGD symptoms have also been associated with depressive symptomatology, functional impairment, and suicidal ideation. Consequently, contemporary bereavement literature considers the assessment of safety concerns, co-occurring psychological difficulties, and broader psychosocial functioning as important

aspects of clinical evaluation following traumatic loss (Szuhany et al., 2021).

7. CONCLUSION

Traumatic loss extends beyond the death of a loved one and encompasses processes involving trauma, attachment, identity, interpersonal relationships, and meaning-making. Contemporary evidence suggests that symptoms of Prolonged Grief Disorder (PGD) frequently co-occur with posttraumatic stress symptoms following traumatic bereavement, contributing to the complexity of clinical presentation and psychological adjustment. Understanding traumatic loss, therefore, requires consideration of the circumstances of the death, attachment patterns, social support resources, functional impairment, and co-occurring psychological difficulties.

Psychodynamic perspectives contribute to this understanding by emphasizing the individual's ongoing internal relationship with the deceased, experiences of ambivalence, guilt, defense mechanisms, and identity-related processes. At the same time, current research demonstrates that bereavement is not solely an individual phenomenon but is also closely linked to relational factors such as relationship satisfaction, communication patterns, social support, emotional intimacy, and physical closeness. Within couple relationships, partners' perceptions of grief, coping orientations, and shared meaning-making processes appear to play important roles in post-loss adaptation.

Taken together, the literature supports a multidimensional understanding of traumatic loss and prolonged grief that incorporates psychological, relational, cultural, and interpersonal dimensions. Such a perspective facilitates a more comprehensive conceptualization of bereavement and highlights the complex

interplay between individual experiences of loss and the broader relational contexts in which grieving occurs.

8. FUTURE DIRECTIONS

Future research may further advance understanding of traumatic bereavement by examining relational processes, couple dynamics, and prolonged grief symptoms across diverse cultural contexts and through longitudinal designs. Such work may contribute to a more nuanced understanding of adaptation to loss and the interpersonal dimensions of bereavement over time.

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DISASTER AND MENTAL HEALTH: FROM PSYCHOLOGICAL FIRST AID TO LONG- TERM THERAPEUTIC APPROACHES

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1. INTRODUCTION

Disasters are crisis situations that disrupt the lives of individuals and communities, either suddenly or gradually, resulting in severe physical, social, economic and psychological consequences. As well as natural disasters such as earthquakes, floods, droughts and wildfires, wars, terrorist attacks, technological accidents and incidents of mass violence can also have traumatic effects on large populations. In recent years, disasters have become more frequent and destructive on a global scale due to climate change, rapid urbanisation, migration, and increasing social vulnerabilities. This situation means we need to evaluate disasters in terms of both physical losses and their short- and long-term effects on individuals' mental health.

From a clinical psychology perspective, disasters are viewed as traumatic life events that disrupt an individual's sense of safety and control, as well as their core beliefs about the future. Following a disaster, individuals may experience intense emotional reactions such as fear, anxiety, helplessness, anger, guilt, grief and hopelessness. They may also exhibit impairments in cognitive processes such as attention, memory, decision-making and daily functioning. While many of these reactions are considered a normal stress response to the traumatic experience,

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some individuals may develop clinical conditions such as acute stress disorder (ASD), post-traumatic stress disorder (PTSD), depression, anxiety and sleep disorders.

Research in the field of disaster mental health demonstrates that the effects of trauma are not limited to the immediate aftermath of a disaster; psychological consequences can persist for months or even years. For this reason, post-disaster mental health services should not be limited to interventions focused solely on the crisis moment; they must be addressed within a comprehensive framework, ranging from early-stage support measures to long-term, evidence-based psychological interventions.

This section examines the multidimensional effects of disasters on mental health from a clinical psychology perspective; it explores psychological first aid practices within the context of early-stage post-disaster interventions and evaluates research findings regarding the theoretical foundations and effectiveness of long-term psychological interventions.

2. THE MULTIDIMENSIONAL CONSEQUENCES OF DISASTERS ON MENTAL HEALTH

Disasters are events that disrupt the normal course of life, overwhelm a community's coping resources, and have severe impacts on communities (Morganstein & Ursano, 2020). From a clinical psychological standpoint, disasters are defined as traumatic life events that abruptly disrupt individuals' sense of security, sense of control, and belief in a just world. This disruption can render an individual's normal adaptive capacity ineffective (Hobfoll et al., 2007). Disasters can be categorised into three distinct groups based on their causative agents: namely, natural disasters, human- and technology-induced disasters, and complex disasters. Natural disasters are defined as geological and

meteorological events arising from the Earth's natural processes. Examples of such phenomena include earthquakes, floods, storms, hurricanes, droughts and wildfires (Saeed & Gargano, 2022). Terrorist attacks, mass violence incidents, and nuclear accidents are examples of human-induced disasters (Mao & Agyapong, 2021). Complex disasters, in contrast, are characterised by the confluence of elements stemming from both natural and technological/human-induced disasters. The nuclear accident that occurred in the aftermath of the earthquake and tsunami in Fukushima, Japan, is an illustrative example of this phenomenon (McFarlane & Williams, 2012). Disasters are categorised into two distinct groups based on their rate of occurrence: sudden events and slow-onset events. According to Morganstein and Ursano (2020), events such as earthquakes, tsunamis, storms and hurricanes are classified as sudden-onset disasters, while disasters such as droughts are considered slow-onset disasters. Disasters have been shown to cause physical, economic, social, psychological, and environmental damage, leading to mass crises (Makwana, 2019). These phenomena pose a threat to human life and social order, resulting in the loss of social resources and disruptions to social life. Furthermore, these phenomena have the potential to precipitate both physical and mental health concerns among individuals confronted with disaster (Saeed & Gargano, 2022).

The effects of disasters on mental health are examined from multiple perspectives. These effects, which exhibit a heterogeneous structure, vary depending on the source of the event, its duration and intensity, the degree of exposure, and the passage of time. The effects of disasters on mental health are not one-sided. At the same time, the characteristics of individuals exposed to disasters, as well as the characteristics of the community, influence the level and form of impact from the disaster. A study utilising 160 samples, encompassing

approximately 60,000 individuals, revealed that mass violence incidents, such as terrorism and armed attacks, exert a more detrimental influence on individuals than natural disasters (Norris et al., 2002). It has been hypothesised that the primary reason for this discrepancy is that such events have a greater impact on individuals' positive beliefs about themselves and the world than other types of disasters. In contradistinction to natural disasters, such events are characterised by deliberate intent and malevolent intent. Moreover, the study demonstrates that women, children and adolescents, individuals with inadequate social support, and those of lower socioeconomic status are more negatively affected by disasters (Norris et al., 2002). These findings lend further support to the multidimensional nature of the relationship between disasters and mental health.

The psychological effects of a disaster are categorised as either acute or long-term effects. In the acute and early phases – that is to say, in the days and weeks immediately following the disaster – the psychological reactions observed are quite intense. In the aftermath of such a traumatic life event, it is not uncommon for individuals to experience a range of emotions, including fear, shock, anger, helplessness, anxiety, sadness, and unhappiness. Such alterations in emotional state have been demonstrated to manifest concomitantly with alterations in cognitive processes. Individuals may experience difficulties in decision-making, difficulty in maintaining concentration, and feelings of disorientation (Morganstein & Ursano, 2020). As Heanoy and Brown (2024) hypothesise, post-disaster, there may be observed changes in appetite and excessive startle responses. It is important to note that these reactions do not necessarily signify a clinical disorder; they can be regarded as normal responses to an abnormal situation.

In the aftermath of a disaster, the initial phase of the first month following the disaster is characterised by symptoms that

are typically associated with acute stress disorder (ASD). ASD is defined as a trauma-based psychopathological condition that emerges after an individual is exposed to a traumatic event and is observed within the first month following the event. According to the DSM-5, ASD is characterised by intrusive symptoms, dissociation, avoidance, negative mood, and increased arousal (APA, 2013). Intrusive symptoms refer to the occurrence of repetitive, involuntary, and distressing memories in individuals following a disaster. The individual may experience the traumatic event in a dream state, feel as if they are reliving the event, or experience intense psychological distress in response to stimuli that remind them of the event. Symptoms of dissociation may appear as an altered perception of reality regarding one's surroundings or oneself, or as an inability to recall key aspects of the traumatic events the person has experienced. Symptoms of avoidance involve efforts to distance oneself from thoughts, memories, and emotions associated with the traumatic life event, as well as from stimuli that remind one of the event. Arousal symptoms include being constantly on guard, difficulty falling asleep or staying asleep, and exaggerated startle responses (APA, 2013). For a diagnosis of ASD, the individual must meet the diagnostic criteria, and these symptoms must have lasted for at least three days and no more than one month (APA, 2013).

The prevalence rates and severity of clinical symptoms of ASD vary significantly depending on the type of disaster, its scale of destruction and severity, as well as individuals' levels of exposure and their sociodemographic (age, gender) and psychological characteristics. A review of the extant literature clearly demonstrates this variability. While ASD symptoms were identified in 74.5% of children and adolescents under the age of 18 who experienced direct exposure following the 1999 Marmara Earthquake (Abali et al., 2002), this rate was reported to be 24.9% among disaster survivors in the Philippines following Typhoon

Haiyan (Lavenda et al., 2017). In a further study that examined the effect of exposure levels, the prevalence of ASD was measured at 40.5% among individuals who were directly exposed to the September 11 attacks; among those who were not directly exposed to the event, this rate was observed to drop to 20.4% (Fullerton et al., 2004). Finally, in a recent study conducted with an adolescent sample following the 2023 Kahramanmaraş Earthquakes, it was reported that a high proportion of participants – 81.6%, to be precise – received an ASD diagnosis, thereby highlighting the psychological impacts of the disaster's severity (Efendi et al., 2023).

The elevated incidence of ASD in the immediate aftermath of disasters serves to underscore the deleterious consequences of trauma in its nascent stages. Nevertheless, the repercussions of disasters on mental health are not confined to the acute post-event period. In the absence of timely and appropriate psychosocial interventions for these initial acute symptoms, there is a high risk that the condition will evolve into long-term mental health issues such as Post-Traumatic Stress Disorder (PTSD), major depression, and chronic anxiety. Despite the heterogeneity of natural disasters in terms of their types and geographical locations, extant research in the relevant literature supports the view that the devastating effects of such events on individuals' mental health constitute a global problem. For instance, a study undertaken by Rahman et al. (2025) approximately six months after the 2024 Feni flood disaster in Bangladesh emphasised the profound psychosocial ramifications of the disaster. The study reported that 52.80% of participants exhibited severe depression, 44.17% exhibited severe anxiety, and 46.90% exhibited severe stress symptoms (Rahman et al., 2025). In another study examining the temporal course of the psychological effects of natural disasters, individuals exposed to the 2021 wildfires in British Columbia, Canada, were assessed longitudinally 3 and 12

months after the disaster. The findings revealed that participants exhibited high levels of depression, anxiety, and stress symptoms immediately following the fire, but these symptoms showed a tendency to decrease over time (Heanoy et al., 2025). However, it is also known that the traumatic effects of certain types of disasters can persist for many years. A study conducted four years after the 8.8-magnitude earthquake in Chile found that individuals who experienced the earthquake continued to exhibit significant levels of stress and depressive symptoms (Garfin et al., 2014). Similarly, data collected five months after the 2015 Nepal earthquake revealed that approximately one-third of disaster survivors exhibited significant levels of anxiety, depression, and anger management issues; furthermore, 5.2% of participants developed symptoms of PTSD (Kane et al., 2018). When these findings are evaluated holistically; it is clear that while the type of natural disaster experienced (flood, fire, earthquake) and the time elapsed may vary, disasters cause deep and sometimes chronic psychological damage to individuals' mental health; therefore, both short- and long-term, sustainable psychosocial support interventions are a vital necessity in post-traumatic recovery processes.

3. EARLY INTERVENTION AFTER DISASTER: PSYCHOLOGICAL FIRST AID

Psychological First Aid (PFA), a concept that has gained global recognition, is defined as a form of humanitarian and supportive assistance provided to individuals affected by traumatic life events (IASC, 2007). This approach is defined as practical, non-interventional, and empathetic assistance provided to those who are suffering or in need of support (Bisson & Lewis, 2009). The World Health Organization (WHO) does not regard PFA as a clinical intervention or diagnostic method, but rather as

a supportive response offered by one person to another. The PFA's primary objective is to provide immediate support to individuals impacted by disasters. This assistance is typically provided during the disaster or immediately afterwards. The fundamental components of this intervention encompass addressing primary needs, active listening, emotional support, and the provision of information and services.

Despite the existence of numerous PFA models, three models (namely, WHO-PFA, NCTSN-PFA and RAPID-PFA) are frequently cited as effective. Each model prioritises different considerations and has been developed for distinct populations (Wang et al., 2021). The WHO-PFA model, developed by the World Health Organization (WHO), is a widely utilised framework in a variety of international settings. The model is based on three steps: Look, Listen, and Link. The first step, the look stage, primarily involves observing the disaster area. Disaster areas can be quite complex, especially during and immediately after a crisis. It is important to observe the surroundings before intervening. First, the safety situation must be assessed. One should check for damaged or collapsed buildings and structures, the presence of an ongoing fire or flood, and whether there is an ongoing conflict. If individuals are not certain of the area's safety, they should not enter the zone and should warn others in the area. The health status of individuals or animals in the disaster area, whether they require medical assistance, and the status of basic needs such as shelter and food must be assessed. Additionally, during this phase, individuals exhibiting shock, difficulty moving, or extreme sadness and fear are identified. The second step—the listening phase—is the stage of establishing communication to understand the circumstances and possible needs of disaster-affected individuals, to calm them down, and to listen to them. During this phase, individuals are approached with respect and in a culturally appropriate manner,

and they are asked if they would like assistance. Their needs, wishes, and the situations that frighten or worry them are identified. Individuals are listened to without judgment if they choose to share their stories, and they are not pressured to speak. The final stage, known as the link stage, aims to help individuals access the resources they need. Individuals are assisted in accessing basic necessities and services. Practical support is provided to meet the most urgent needs, such as shelter, food, water, and healthcare, and individuals are referred to relevant agencies. Efforts are made to keep families together, facilitate communication with loved ones, and, where available, connect them to religious or cultural support networks.

Another model, the RAPID PFA model developed by Johns Hopkins, consists of the following steps: Rapport, Assessment, Prioritization, Intervention, and Disposition (Wang et al., 2021). The NCTSN-PFA offers a more comprehensive approach. The model includes the steps of establishing contact, ensuring safety/comfort, stabilization, information gathering, practical assistance, connecting to social support, coping strategies, and referral/discharge (Wang et al., 2021).

In conclusion, Psychological First Aid is an early-stage, preventive intervention approach focused on ensuring the safety, calming, support, and fulfillment of basic needs of individuals following disasters and traumatic events. Rather than a clinical treatment method, it is a form of humanitarian aid aimed at alleviating an individual's current stress responses, supporting their functioning, and helping them reconnect with social support networks. Although different models such as WHO-PFA, RAPID-PFA, and NCTSN-PFA vary in terms of application areas and target groups, the common thread among all models is ensuring safety, establishing empathetic communication, identifying needs, and referring individuals to appropriate support mechanisms. In this regard, PFA provides a crucial foundational

intervention framework for protecting mental health and supporting long-term psychosocial well-being during disasters and crises.

4. LONG-TERM PSYCHOLOGICAL INTERVENTIONS FOLLOWING A DISASTER

The repercussions of disasters on mental health and the implementation of psychological first aid practices represent the fundamental components of early-phase interventions following a disaster. Nevertheless, the psychological consequences of disasters frequently extend beyond the initial acute phase, with the repercussions of traumatic experiences often persisting for months or even years. Consequently, the provision of long-term psychological interventions within the remit of post-disaster mental health services is of critical importance. There is a particular requirement for structured, evidence-based psychological interventions to prevent the chronic development of psychopathological symptoms such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, grief reactions, sleep problems, and loss of functioning.

The purpose of long-term psychological interventions following a disaster is to assist individuals in comprehending their traumatic experiences, enhancing their emotional regulation capabilities, and recuperating their capacity to function in daily life. These interventions can be delivered in various forms, including individual therapy, group therapy, family-based approaches, community-based psychosocial support programs, and online mental health services. The primary objective of long-term interventions is not merely to mitigate symptoms, but also to enhance the individual's psychological resilience and facilitate their social reintegration.

As demonstrated by the preponderance of scientific evidence, the most efficacious post-disaster psychological interventions are Prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), Cognitive Therapy (CT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is a psychological intervention that aims to reshape dysfunctional cognitions related to traumatic experiences, thereby reducing avoidance behaviours and facilitating the processing of traumatic memories in a controlled manner in individuals following a disaster. A meta-analysis study encompassing 64 studies demonstrated that exposure therapy, cognitive processing therapy, and cognitive-behavioral therapies are effective intervention methods with a high level of evidence in the treatment of PTSD (Cusack et al., 2016). A similar finding was reported in a meta-analysis conducted by Kline et al. (2018), which found that exposure-based therapies had a significantly higher effect size compared to other interventions, particularly during the post-treatment and follow-up periods. The findings of the systematic review by Lewis et al. (2020) indicate that the interventions with the strongest clinical evidence for reducing PTSD symptoms in adults are CBT, PE, and CT.

Another important approach used in post-disaster mental health services is Narrative Exposure Therapy (NET). Originally developed for victims of war, torture, and organized violence, this method has, over time, also come to be applied following natural disasters, forced migration, terrorist attacks, and mass traumas. The NET approach aims to help individuals re-examine their traumatic experiences within the framework of a structured life narrative and confront traumatic memories under safe conditions. This approach contributes to the interpretation of traumatic events by evaluating the individual's life story in a holistic manner. Studies conducted particularly following war, migration, and terrorist attacks demonstrate that NET interventions are effective

in reducing trauma symptoms (Neuner et al., 2008). A study involving refugees and asylum seekers reported that NET interventions resulted in a significant reduction in PTSD and depression levels (Stenmark et al., 2013). Current research findings examining the effectiveness of psychotherapy methods used in the treatment of earthquake-related PTSD also reveal that CBT and NET interventions significantly reduce earthquake-related PTSD symptoms compared to control groups (Haktanir & Kurnaz, 2025).

In recent years, online psychological interventions have become increasingly widespread in the field of disaster mental health, in parallel with technological advancements. The utilisation of internet-based therapy applications has gained importance, particularly in disasters affecting large populations, due to limited access to in-person mental health services. A plethora of studies have demonstrated the efficacy of online interventions in reducing symptoms of anxiety (Stasiak et al., 2016), as well as symptoms of PTSD, depression, and insomnia (Belleville et al., 2023) in the aftermath of disasters. However, the efficacy of online interventions can be influenced by various factors, including the individual's level of access to technology, digital literacy, social support resources, and consistent participation in the intervention.

Long-term psychological interventions following a disaster play a significant role in helping individuals to rebuild their psychological well-being and to support their social functioning after traumatic experiences. The utilisation of evidence-based psychotherapy approaches has been demonstrated to be efficacious in the reduction of psychopathological symptoms that may develop subsequent to trauma, as well as in the prevention of chronicity. However, the provision of post-disaster mental health services must be addressed not only at the individual level but also within a social

and cultural context. The increasing prevalence of online interventions alongside technological advancements offers significant opportunities for access to mental health services. However, further research is needed to enhance the effectiveness of these applications. It is imperative that future research in the domain of disaster mental health prioritises the cultural adaptability, sustainability, and accessibility of long-term psychological interventions.

5. CONCLUSION

Disasters are traumatic experiences that cause physical destruction, economic losses and profound psychological distress, affecting individuals' sense of security and social functioning. The psychological reactions experienced following a disaster can vary depending on numerous factors, including the individual's level of exposure to the disaster, its type and severity, the availability of social support resources, the cultural context and the individual's psychological characteristics. For this reason, disaster mental health is a multidimensional field of study that requires a biopsychosocial approach.

The findings discussed in this section suggest that disasters can result in significant mental health issues in both the short and long term. Although intense stress reactions such as fear, anxiety, shock and feelings of helplessness are often natural and expected responses in the immediate aftermath of a disaster, in some individuals these symptoms can become chronic and evolve into psychopathological conditions such as ASD, PTSD, depression and anxiety disorders. Early interventions are therefore of critical importance at this stage. One of the fundamental components of the initial response process following a disaster is the practice of Psychological First Aid, which focuses

on ensuring safety, meeting basic needs, calming the individual, and re-establishing connections with social support systems.

Furthermore, post-disaster mental health services should not be limited solely to early-stage interventions. Given the long-term effects of trauma, structured, evidence-based psychological interventions must be provided sustainably. Methods such as trauma-focused cognitive behavioural therapy, exposure therapies, cognitive processing therapy and narrative-based interventions are widely recognised in the literature as effective in reducing PTSD and related psychopathologies. Furthermore, the increasing availability of online mental health services offers significant opportunities to improve accessibility, particularly in disasters affecting large populations.

In conclusion, disaster mental health services constitute a comprehensive field of intervention that goes beyond providing support during a crisis, aiming to restore individuals' long-term well-being, psychological resilience, and social adaptation. It is imperative that future studies concentrate on the development of culturally sensitive and accessible intervention models, the expansion of preventive mental health programmes for at-risk groups, and the assurance of the sustainability of post-disaster psychosocial support systems. In communities frequently exposed to disasters, the integration of mental health services within disaster management policies is imperative for facilitating both individual and societal recovery processes.

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KLİNİK PSİKOLOJİ ALANINDA AKADEMİK
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