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**EXAMINING THE PREDICTOR ROLE OF ALEXITHYMIA DEGREE**  
**ON GRIEF EXPERIENCE IN BEREAVED INDIVIDUALS**

**BY**

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Tez Başlığı: Examining the Predictor Role of Alexithymia Degree on Grief Experience in Bereaved Individuals

Yukarıda başlığı belirtilen Yüksek Lisans tez çalışmamın; Giriş, Ana Bölümler ve Sonuç Bölümünden oluşan, toplam 35 sayfalık kısmına ilişkin, 10/06/2025 tarihinde tez danışmanım tarafından Turnitin adlı intihal tespit programından aşağıda belirtilen filtrelemeler uygulanarak alınmış olan orijinallik raporuna göre, tezimin benzerlik oranı %17'dir. Uygulanan filtrelemeler:

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## ÖZET

**ÇAKMAK, Bilge. Kayıp Yaşayan Bireylerde Aleksitimi Düzeyinin Yas Deneyimi Üzerindeki Yordayıcı Rolünün İncelenmesi. Başkent Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Yüksek Lisans Programı. Ankara, 2025.**

Bu araştırma kapsamında kişilerin bir yakınıni kaybettikten sonra deneyimledikleri yas süreci ve tepkileri ile aleksitimi düzeyinin arasındaki ilişkinin incelenmesi amaçlanmıştır. Bu ilişki incelenirken aleksitiminin yas tepkileri üzerindeki yordayıcı rolü dikkate alınmıştır. Araştırmaya katılım sağlayan toplam 106 katılımcının yaşları 18-60 arasındadır. Bu katılımcılar en az 6 ay en fazla 1 yıl önce bir yakınıni ölüm sebebiyle kaybetmişlerdir. Çalışmaya katılmayı kabul eden kişilere sırasıyla Bilgilendirilmiş Onam Formu ve Demografik Bilgi Formu verilmiştir. Sonrasında ise 20 maddelik Toronto Aleksitimi Ölçeği (TAÖ-20) ve Hogan Yas Tepkileri Tarama Listesi (HYTL) uygulanmıştır. Toplanan veriler basit doğrusal regresyon ve aşamalı çoklu regresyon istatistiksel analizlerden geçirilmiştir. HYTL ölçeğinin beş negatif yas tepkisi ve bir pozitif yas tepkisi olacak şekilde toplamda 6 alt ölçeği bulunmaktadır. Negatif yas tepkilerini içeren beş alt ölçek Misery Scale başlığı altında toplanmış ve belli analizlere bu şekilde dahil edilmiştir. Yapılan analizler sonucunda aleksitimi düzeyinin negatif yas tepkilerini anlamlı bir şekilde pozitif yönde yordadığı, pozitif yas tepkilerini yani kişisel gelişimi ise negatif yönde anlamlı bir şekilde yordadığı sonucuna ulaşılmıştır. Bunlara ek olarak aleksitiminin “duyguları tanımda güçlük” alt boyutunun negatif yas tepkileri ile, “dışa vuruk düşünme” alt boyutunun ise pozitif yas tepkileri ile en çok ilişkili olduğu sonucu elde edilmiştir. Elde edilen sonuçlar var olan literatür ile birlikte yorumlanmış ve bu çalışmanın güçlü yönleri, kısıtlılıkları ve gelecek çalışmalara olan yönlendirmesi ve katkıları tartışılmıştır.

**Anahtar Kelimeler:** Aleksitimi, yas, yas tepkileri, duygular, kişisel gelişim

## ABSTRACT

**ÇAKMAK, Bilge. Examining the Predictor Role of Alexithymia Degree on Grief Experience in Bereaved Individuals. Başkent University, Institute of Social Sciences, Master Program of Clinical Psychology with Thesis. Ankara, 2025.**

This study aimed to examine the relationship between individuals' levels of alexithymia and their experiences and responses during the grieving process following the loss of a loved one. In this context, the predictive role of alexithymia on grief reactions was investigated. The study included a total of 106 participants aged between 18 and 60. These participants had lost a close relative due to death at least 6 months and at most 1 year prior to the study. Those who agreed to participate were first presented with an Informed Consent Form and a Demographic Information Form. Following this, the 20-item Toronto Alexithymia Scale (TAS-20) and the Hogan Grief Reaction Checklist (HGRC) were administered. The collected data were analyzed using simple linear regression and stepwise multiple regression analyses. The HGRC includes six subscales in total that include five negative grief reactions and one positive grief reaction. The negative grief reactions were grouped under the heading "Misery Scale" and were treated as a single measure in some of the analyses. The analyses revealed that the level of alexithymia significantly and positively predicted negative grief reactions, while it significantly and negatively predicted positive grief reactions which is personal growth. Furthermore, it was found that the "difficulty identifying feelings" dimension of alexithymia was most strongly associated with negative grief reactions, whereas the "externally oriented thinking" dimension was most strongly associated with positive grief reactions. The findings were interpreted in the context of the existing literature, and the strengths, limitations, and implications of the study for future research were discussed.

**Key Words:** Alexithymia, grief, grief reactions, feelings, personal growth

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## **LIST OF ABBREVIATIONS**

APA	American Psychological Association
DDF	Difficulty Describing Feelings
DIF	Difficulty Identifying Feelings
DSM-5	Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition – Text Revision
EOT	Externally-Oriented Thinking
HGRC	Hogan Grief Reaction Checklist
IBM	International Business Machines
ICD-11	International Classification of Diseases – Eleventh Revision
MDD	Major Depressive Disorder
OCD	Obsessive Compulsive Disorder
PCBD	Persistent Complex Bereavement Disorder
PD	Panic Disorder
PGD	Prolonged Grief Disorder
PTSD	Post-Traumatic Stress Disorder
SPSS	Statistical Package for Social Sciences
TAS-20	Toronto Alexithymia Scale – 20 Item

# 1. INTRODUCTION

## 1.1. Alexithymia

The literature on alexithymia dates back more than 50 years. In the 1920s, while the body and mind debates were ongoing, certain somatic diseases began to be associated with the inability to process and identify emotions, focus on external events and lack of fantasy (Luminet & Nielson, 2024). In the following periods, scholars such as Alexander (1950), Ruesch (1948), MacLean (1949) continued to work in this field and contributed to the concept of alexithymia.

Alexithymia was formulated and introduced into the literature by Nemiah and Sifneos (Nemiah & Sifneos, 1970; Sifneos, 1967), who worked with classical psychosomatic illnesses with a psychoanalytic approach, as a result of their research and observations (Taylor, 2004). Sifneos (1973) coined the Greek term alexithymia (a: lack, lexis: word and thymos: mood or emotion). Later on, alexithymia was identified not only in psychosomatic disorders but also in various other psychopathologies (Taylor, 2004).

What is alexithymia defined as? Is it a disorder, a language deficiency, a trait? First of all, if there is no neurological or psychiatric disease or if it is not seen as a side effect of the medication used, alexithymia has been defined as a stable psychological trait that lasts a lifetime and shows little change in non-clinical populations (Luminet et al., 2001; Picardi et al., 2005; Rufer et al., 2006). Alexithymia cannot be said to be either present or absent in a person, i.e in other words it is not categorical, instead it is defined as a personality trait that is present in different degrees in every person and has various dimensions (Luminet & Nielson, 2024). Hence, alexithymia is the mode of behavior, thought and reaction during one's experiences and is referred as a difficulty rather than an inability. Each person may have different degrees of alexithymia and different components may be predominant, resulting in individual differences (Luminet & Nielson, 2024). Many studies have been conducted to investigate whether alexithymia is a stable personality trait. An example of this, Salminen et al. (1994) observed a group of general psychiatric patients for one year and found a decrease in psychological distress but no significant change in mean alexithymia score.

There are three main components of alexithymia that are currently agreed upon. The first of these three components is difficulty identifying feelings (DIF) which refers to the lack of ability to recognize and to differentiate between emotional states. People with high DIF may only describe their experience as discomfort rather than distinguishing which

negative emotions they feel in a situation and indicating a specific emotion (Luminet & Nielson, 2024). In addition, they may also have challenges in separating bodily sensations and emotions (Desmedt et al., 2025). Another component, difficulty describing feelings (DDF), differs from DIF in that the person may have difficulty explaining their feelings to other people. The last component, externally oriented thinking (EOT), refers to a cognitive style that focuses on external factors and details rather than internal situations and experiences, an operative thinking style (Nemiah et al., 1976).

Although alexithymia is a stable trait, recommendations and specific approaches have been proposed for its treatment, but future studies are still needed to contribute to treatment planning and improve treatment processes. While Sifneos (1996) and Nemiah et al. (1976) prefer individual or group psychotherapies for the treatment of alexithymia, Krystal (1979, 1982) prefers individual psychotherapy with specific psychoeducational techniques to target deficits in affect awareness and affect tolerance. Beresnevaite (2000) found that alexithymic features decreased in patients who received group psychotherapy after myocardial infarction (post-MI).

### **1.1.1. Etiology of alexithymia**

Although there are many different approaches explaining the causes of alexithymia, three models are taken as main. One of these is the *developmental models*, which suggests that children who are not encouraged to share and understand their emotions (Lane & Schwartz, 1987) or fail to form emotional bonds with their caregivers (Li et al., 2003a), may miss critical stages in emotional development. This model states that skipping these developmental milestones may hinder the development of emotional awareness in the person (Luminet & Nielson, 2024). In line with these, childhood traumas (such as trauma, neglect, abuse) and insecure attachment styles (avoidant or anxious attachment) that may develop as a result of these traumas have been associated with alexithymia (Bucci, 1997b; Panayiotou et al., 2018; Schimmenti & Caretti, 2018). In addition to developmental factors in childhood, physical traumas experienced in adulthood (Hobson et al., 2019; Hogeveen & Grafman, 2021) or psychological traumas (Krystal, 1995) have also been offered as explanations for alexithymia.

Another model explaining alexithymia is the *cognitive models* that involve the process of transforming emotional states into cognitive states. In these models, which Bucci (1997a, b) states to take place in two stages, impairments in the transition process are associated with alexithymia. Language, which enables naming the emotional context and feelings, labeling

experiences as feelings and transferring emotions to others, has a role in the process of transition to cognitive states (Luminet & Nielson, 2024). Deficits in early language development can lead to problems in these skills. The language hypothesis of alexithymia suggests that poor emotion concept formation can lead to difficulty in identifying feelings (DIF), one of the dimensions of alexithymia, and poor social-linguistic development can lead to difficulty in expressing feelings (DDF), another dimension of alexithymia (Hobson et al. 2019, Lee et al. 2022). Intense bodily sensations may be experienced because a deficit or limitation in the transition process in these two stages makes it difficult to interpret and transfer experiences (Taylor & Bagby, 2004). This limited processing ability makes it difficult to distinguish between emotions and contexts (Diaz & Prinz, 2023) and can lead to a pathway in which a person focuses on environmental details (EOT) rather than emotionally describing events (Luminet et al., 2004).

*Emotion regulation*, another model, is the process of evaluating, controlling and modifying physiologically, behaviorally and cognitively conscious or unconsciously functioning emotional responses (Luminet et al., 2021). Difficulties in the stages of the attention appraisal model presented by Preece et al. (2017) lead to maladaptive emotion regulation strategies. Difficulties in paying attention to emotional stimuli are associated with EOT, while difficulties in appraisal are associated with DIF and DDF. Findings in the literature confirm the relationship between high alexithymia and deficits in emotion regulation and excessive maladaptive strategy use (Luminet & Zamariola, 2018; Preece et al., 2023).

Emotion knowledge and emotion regulation play an important role in the cognitive processing of emotions (Izard et al., 2011). Emotion knowledge has three core concepts: detecting, identifying and recognizing emotions (in self and others); labeling emotions (in self and others); and understanding the situations that cause emotions and the emotions that arise as a result of situations (Izard, 2009; Izard et al., 2011).

Numerous studies have been conducted to explore the relationship between alexithymia and emotion recognition. For instance, in a study examining the visual identification of emotional expressions, Prkachin, Casey, and Prkachin (2009) measured participants' ability to identify facial expressions representing six basic emotions (happiness, sadness, anger, disgust, surprise, and fear) and found that individuals with high alexithymia had more difficulty in identifying sadness and fear than other emotions and also made more mistakes such as perceiving fear as happiness. In addition to this, they found that people with

high alexithymia scores had great difficulty in processing the emotion of fear at the level of automatic detection and controlled appraisal.

In addition to research using visual stimuli, there have been several studies using auditory stimuli to investigate emotion recognition. A notable example of this, Bayot et al. (2014), in their research on the recognition of non-verbal emotional vocalizations classified as falling into 10 basic emotional states (achievement, amusement, anger, contentment, disgust, fear, sensual pleasure, relief, sadness, and surprise), observed that participants with high alexithymia were more unsuccessful in recognizing negative vocalizations.

In their research examining the relationship between emotion regulation, aggression and alexithymia, Edwards and Wupperman (2017) found that emotion regulation difficulties played a mediating role between alexithymia and impulsive aggressive behaviors.

### **1.1.2. Alexithymia and other disorders**

It should be kept in mind that there is a correlational relationship between alexithymia and other disorders, and no conclusion can be made about causality (Taylor, 2004). There are studies showing that decreased ability to cope with stressful situations and poor interpersonal relationships are associated with alexithymia (Parker et al., 1998; Taylor & Bagby, 2000).

It is known that insecure attachment styles developed in childhood contribute to the risk of psychopathology in adulthood (Bifulco & Thomas, 2012). The same statement can be made for alexithymia, also by its very definition, and the literature supports the relationship between insecure attachment styles and alexithymia. While examining attachment styles and alexithymia, there are studies that take into account childhood traumas that play a role in determining the attachment style, as well as studies conducted with trauma experiences in adulthood.

Sifneos (1988) made two classifications as primary or constitutional alexithymia, in which neurobiological conditions are cited as the cause, and secondary alexithymia, in which psychological trauma or developmental obstacles are cited as the cause. With recent developments, it is hypothesized that secondary alexithymia is shaped by traumatic events experienced in older ages rather than childhood developmental stages and may be formed as a protection method (Schimmenti & Caretti, 2018).

In parallel to these, research has shown that alexithymia degree are positively predicted by emotional and physical neglect (Zlotnick, Mattia & Zimmerman, 2001) and are associated with childhood trauma (Paivio & McCulloch, 2004; Terock et al., 2016).

When the sub-dimensions of alexithymia are examined Goldsmith and Freyd (2005) found a relationship between child emotional abuse and negative home environment experiences and DIF component in a study in which they controlled for depression, anxiety, dissociation and traumatic events. Additionally, they found that parents' excessive punishment was associated with the EOT component of alexithymia. Another research was conducted by Güleç et al. (2013). In this study, they found that the relationship between alexithymia and childhood trauma remained still significant after somatization, depression and anxiety were controlled. Furthermore, they concluded that alexithymia was predicted by emotional abuse, emotional neglect and sexual abuse.

In the existing literature, there are also studies that examine the relationship between alexithymia and trauma from a pathological perspective. In a meta-analysis conducted by Frewen et al. (2008), there is a large effect size for the relationship between PTSD and alexithymia. In another study supporting these findings, it was concluded that alexithymia degree was positively associated with PTSD symptoms (Craparo et al., 2014). Gao et al. (2015) examined the relationship between alexithymia, trauma and attachment and found that DIF and DDF were associated with PTSD and certain symptoms, attachment anxiety was associated with PTSD symptoms, attachment avoidance was associated with only PTSD separation symptoms, and finally, attachment anxiety and DIF predicted PTSD.

When attachment styles are taken into consideration, studies indicate that alexithymia has a positive relationship with attachment anxiety and attachment avoidance (Di Trani et al., 2016; Montebanocci et al., 2004; Picardi, Toni & Caroppo, 2005; Wearden et al., 2003) and a negative relationship with secure attachment (Deborde et al., 2012). Besharat and Khajavi (2013), who also found same results, suggested that defense mechanisms partially mediate the relationships between attachment styles and alexithymia.

It was found that fear of separation, a facet of anxious attachment, predicted alexithymia and DIF component; constraint on closeness, a facet of avoidant attachment, predicted DDF; and low felt attachment, a general facet of insecure attachment, predicted EOT (Oskis et al., 2013).

Lastly, a more comprehensive study, Carpenter and Chung (2011) compared OCD patients with a control group and found a positive relationship between all factors of alexithymia and attachment anxiety, attachment avoidance and child abuse, and also tested that childhood neglect and abuse predicted attachment insecurity, which in turn predicted alexithymia, with the path-analytic model they built and got a positive result.

In the literature, depression is one of the most studied subjects with alexithymia and the general conclusion is that alexithymia is higher in patients with depression. Li et al. (2015) aimed to examine the association between depression and alexithymia in their meta-analysis and found a medium correlation. Studies have found a relationship between the DIF and DDF component of alexithymia and depression, but not a significant relationship between EOT (Bankier et al., 2001; Conrad et al., 2009; Duddu, Isaac, & Chaturvedi, 2003; Honkalampi et al., 2011, Leweke et al., 2012).

In various studies, phobic, psychotic and depressive symptoms were found to be more severe in alexithymic patients with major depressive disorder compared to patients with major depressive disorder without alexithymia (Honkalampi et al., 2007; Kim et al., 2008). In addition to that, Conrad et al (2009) observed that alexithymia predicted the development of other psychopathologies in MDD patients. While some studies in the literature have found that people who experience more severe depression have higher alexithymia scores (Honkalampi et al., 2007; Kim et al., 2008; Vanheule et al., 2007), some studies have stated that alexithymia has no role on depression severity (Gulec et al., 2013; Saarijärvi et al., 2006).

Studies examining the relationship between alexithymia and anxiety disorders highlight their frequent comorbidity and influence on each other. Specifically, the associations between subdimensions of alexithymia and anxiety symptoms have been explored in the context of various psychopathological frameworks.

Dalbudak et al. (2013), who found that social anxiety symptoms of fear, anxiety and avoidance were associated with the DDF factor, also found that “harm avoidance” was associated with alexithymia. In support of these results, another study reported a high prevalence of alexithymia in panic disorder (13.8%), general anxiety disorder (17%), phobic anxiety disorder (26%), mixed anxiety disorders (33%) and mixed anxiety and depressive disorders (22.6%) (Leweke et al. 2012). In the same study, while observing that the significant relationship disappeared when they controlled for anxiety and depressive disorders, Karuviki et al. (2010) stated in their study that the relationship between anxiety and alexithymia did not disappear even when controlling for depression and alcohol consumption.

Moreover, in various studies, it was found that panic disorder (PD) patients had higher degree of alexithymia (Fukunishi et al., 1997; İzci et al., 2014). There was a significant relationship between the DIF and DDF components of alexithymia, but no relationship was found with the EOT component with PD severity (De Berardis et al., 2007). In their 2013

study, Onur et al. working with three patient groups including major depressive disorder, panic disorder and general anxiety disorder found that the patients in these groups had higher alexithymia, especially the DDF component, compared to the control group.

The relationship between alexithymia and various forms of addiction has been widely studied, with research indicating a strong association between alexithymia and substance use disorders, as well as other behavioral addictions. Studies have consistently found elevated alexithymia scores in individuals with substance use disorders, including alcohol and tobacco dependence, and in those struggling with gambling addiction and eating disorders.

A strong relationship has been established between substance use and alexithymia, and this relationship was associated with reward sensitivity and lack of self-regulation (Lyvers et al., 2014). In many studies, high alexithymia scores have been observed in 40-50% of people with substance use disorders (Taylor et al., 1997; Thorberg et al., 2009). For instance, in a study focusing on alcohol users, Thorberg et al. (2011) observed that increased obsessive thoughts about alcohol and compulsive urges to drink were associated with alexithymia. Similarly, Sutherland et al. (2013) identified a relationship between high alexithymia and more cravings during tobacco withdrawal in their study of tobacco users.

In addition to substance use, alexithymia has also been linked to gambling addiction (Lecce & Bagby, 2009; Lumley & Roby, 1995; Toneatto, Mitrovic & Brown, 2009). Furthermore, research on eating disorders has found that 46-69% of anorexia nervosa patients (Eizaguirre et al., 2004; Lulé et al., 2014; Nowakowski et al., 2013; Taylor et al., 1996), 32-61% of bulimia nervosa patients, 39-63% of binge eating disorder patients (Carano et al., 2012; Corcos et al., 2000; de Groot et al., 1995; Nowakowski et al., 2013; Pinaquy et al., 2003) had high alexithymia scores. While significant differences were observed in the DDF and DIF components of alexithymia in eating disorders in general (Amianto et al., 2016; Nowakowski et al., 2013), significant differences were observed in the EOT dimension in specifically anorexia nervosa (Abbate-Daga et al., 2015).

## **1.2. Grief**

Engel (1961) analogizes the grieving process experienced after the loss of a loved one to healing and suggests that, as in a physiological trauma, a healing process is necessary and a period of time is needed to return to a state of psychological balance. Grief is defined as the experience that consists of thoughts, emotions, behaviors and physiological changes experienced by the person after the loss of a loved one; mourning is the process of adapting

to the loss experienced, understanding the certainty and consequences of the loss; bereavement is defined as the loss and loss experience that is tried to adapt (Worden, 2018).

Although grief is a highly individual process, it often manifests through a range of behaviors and responses that can be categorized under common patterns or themes. Worden (2018) grouped these normal grief behaviors under four categories: emotions, physical sensations, cognitions and behaviors. The emotions category includes sadness, anger, blame, guilt and self-reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief and numbness. He mentioned physical sensations such as feelings of depersonalization, tightness in the chest and throat, lack of energy, dry mouth. Under the cognition category, there are confusion, disbelief, preoccupation, sense of presence, hallucinations. The behavioral part of normal grief reactions includes sleep and eating disturbances, distracted and absent-minded behavior, social withdrawal, dreams about the deceased, avoidance, crying, restless hyperactivity, searching and calling out, visiting places or carrying objects related to the deceased. In a successful mourning, the pain and devastation experienced after acute grief, which is the first and turbulent reaction after a loss and where the mentioned reactions are experienced, diminishes and the person adapts to the loss (Shear, 2012). In principle, acute grief is expected to be observed during the first six months after the loss (Shear & Mulhare, 2008).

The grief process has been tried to be explained with different approaches as stages as proposed by Kübler-Ross and Kessler (2009), as phases like Parkes and Prigerson (2010) or as tasks as proposed by Worden (2018). Tasks are suggested as an alternative model because they encourage active involvement in the grieving process, rather than the passive experience of simply going through mandatory phases and stages in order. The first of Worden's (2018) mourning tasks is to accept the reality of the loss. The second task is to process the pain of grief, the third task is to adapt to the world without the deceased, and the last task is to find a way to remember the deceased while moving on.

### **1.2.1. Mediators of grief**

While the experience of grief has many aspects in common, grief is in fact highly individualized and can be experienced differently by everyone in terms of intensity, how long it lasts or when it starts, so there are mediators that cause these differences (Worden, 2018)

Kinship, which can be spouse, child, parent, friend, lover, etc., is one of the strongest predictors of grief (Worden, 2018). The closer the kinship with the deceased, the more

intense the grief is experienced (Boelen, Van den Bout, de Keijser, 2003). Cleiren (1993) found that parents and spouses of the deceased experienced more intense grief than children and siblings.

Grief is also related to the attachment between the person and the person they have lost, and there is usually a positive association between the intensity of the relationship and the intensity of grief reactions (Worden, 2018). The greater the complexity of the relationship, the more difficult the grief experience because if the proportions of positive and negative emotions are close to each other and the relationship is ambivalent, it can lead to feelings of anger and guilt, in addition, if the relationship was a conflictual one, and especially if there was unfinished business before the death that will never be resolved, grief reactions can be even more difficult (Worden, 2018).

How or for what reason the person died is also an important factor affecting grief reactions, including proximity (whether they were near them or away), suddenness/unexpectedness, violent/traumatic deaths, multiple losses (how many losses were experienced in a single event), preventable deaths (whether they considered it as preventable), ambiguous deaths (missing persons whose deaths are unknown), stigmatized deaths (such as AIDS, suicide) (Worden, 2018).

Personality variables are also included in the mediators of grief, such as age, gender, coping style (problem-solving coping, active emotional coping, avoidant emotional coping), attachment style, cognitive style, ego strength (self-esteem and self-efficacy), beliefs and values. In addition to personality variables, social variables also seem to have an effect on the grief experience. The adequacy of the social support the person receives, the presence of religious or cultural rituals that may have an impact on coping with loss, and the number of social roles the person has have a part in the intensity of grief reactions (Worden, 2018).

There is no clarity in the literature about the relationship between grief experience and the age of the person experiencing loss. A relationship has been found between older age and higher levels of PGD due to factors such as reduced social support, loss of long-term relationships, experiencing multiple losses in a short period of time, and reduced resilience (Coifman et al., 2007; Newson et al., 2011; Tofthagen et al., 2017). In contrast, there are also studies that found an association between younger age and higher levels of PGD (Burke & Neimeyer, 2013). However, there are also research with findings that the age of the person experiencing loss is unrelated to the level of PGD (Heeke et al., 2017; Melhem et al., 2003; Morina et al., 2010).

### **1.2.2. The concept of grief as a disorder and depression**

The concepts of normal and pathological grief can be traced back to Freud's "Mourning and Melancholia" (Freud, 1957), where he proposed that depression (or melancholia) could be understood as a pathological form of grief. However, framing grief within a pathological context has raised concerns about overdiagnosis, unnecessary medication, and the risk of stigmatization (Breen et al., 2015; Tang et al., 2020; Worden, 2018). Research exploring the relationship and distinction between grief and depression (Boelen & van den Bout, 2005; Prigerson et al., 1995), findings suggesting grief can remain for many years (Maciejewski et al., 2007; Prigerson et al., 2009), and studies highlighting the distressing and dysfunctional aspects of grief (Maciejewski et al., 2007; Maciejewski et al., 2016) have supported the notion of pathological grief and contributed significantly to its recognition as a disorder (Prigerson et al., 2021).

Considering that depressive disorders and pathological grief share certain commonalities, it is important to mention that they do in fact diverge from each other. Prigerson and colleagues have made substantial contributions to the definition of pathological grief, emphasizing that grief, depression, and anxiety are largely separate constructs, with few shared features (Prigerson et al., 1994, 1995, 1996). Their work has laid the foundation for further studies in this area (Boelen & van den Bout, 2005; Boelen, van den Bout, & de Keijser, 2003).

The literature distinguishing grief from depression is extensive. While both share common symptoms such as deep sadness, low mood, crying, and sleep disturbances, one of the differences is that individuals do not experience a loss of self-esteem during grieving (Worden, 2018). According to the DSM-5-TR (APA, 2022) diagnostic distinction, distress in depressive disorders is associated with an overall low mood, whereas in prolonged grief disorder (PGD), distress is specifically associated with the experience of loss and separation. Cognitive differences are also noted; although negative evaluations about the self, world, and future may occur in both cases, it has been mentioned that they are more temporary (Beck et al., 1979).

Regarding the distinction between these two concepts, Klerman and colleagues (Klerman & Izen, 1977; Klerman & Weissman, 1986) offered an explanation that depression may emerge following a loss or in response to reminders of a loss, while Dorpat (1973) proposed that depression might serve a defensive function. In line with Klerman's perspective, many findings indicating that major depressive episodes can be experienced

during the grieving process (Zisook & Kendler, 2007; Zisook, Paulus, Shuchter, & Judd, 1997; Zisook & Shuchter, 1993; Zisook & Shuchter, 2001).

Worden's (2018) statement "Each person's grief is like all other people's grief; each person's grief is like some other person's grief; and each person's grief is like no other person's grief.", originally attributed to Allport (1957, class lecture), clearly emphasizes the individuality of grieving. Inability to adapting to loss, obstruction of the grieving process, and difficulty in the recovery process can complicate the grief and lead to pathological grief (Shear, 2010).

In the DSM-5 (APA, 2013), complicated grief was not included in a distinct diagnostic category but was listed under "Conditions for Further Study" as Persistent Complex Bereavement Disorder (PCBD) as a candidate disorder and called the need for additional research in this area (Worden, 2018). After decades of debate and its valid inclusion in ICD-11, it was accepted to add prolonged grief disorder (PGD) to the DSM-5-TR in 2020. According to the criteria in DSM-5-TR, a diagnosis of PGD requires that at least 12 months must have passed since the death of a loved one (six months for children and adolescents) (Criterion A). The individual must experience intense longing and/or preoccupation with thoughts or memories of the deceased nearly every day for at least the past month (Criterion B). Additionally, the presence of at least three symptoms of identity disruption, avoidance of reminders, intense emotional pain, emotional numbness, difficulty reintegrating into life, disbelief about the loss, feelings of meaninglessness, or profound loneliness is another diagnostic feature (Criterion C). As stated in Criterion D, the symptoms must cause clinically significant distress or impairment in important areas of functioning, such as social or occupational domains. As this definition suggests, the distinguishing factors between PGD and normal grief lie primarily in the duration, intensity and level of the grief response.

### **1.3. The Relationship Between Grief and Alexithymia**

Grief is a psychological adjustment and healing process that individuals need to go through after experiencing after a loss. Although this process can vary from person to person, it involves a common emotional reactions and behavioral responses. In order to adapt to the loss, cope in a healthy way and achieve recovery, individuals are generally expected to progress through certain stages that involve emotional experiences. Since alexithymia is related to difficulties in identifying, describing and expressing feelings, it may have a significant role in the grieving process. Individuals with high levels of alexithymia may be considered potential obstacles in the individual's path to healing during the grief.

There are gaps in the literature regarding the relationship between grief and alexithymia, however, it is possible to highlight several important studies. Studies have generally been conducted with participants diagnosed with complicated grief or at high risk of diagnosis. Moreover, depression is included in the majority of studies on grief. For instance, in their study that intended to investigate the relationship of alexithymia, depression and grief levels in patients with PCBD, Kaya and Aydemir (2021) found that participants with alexithymia experienced more severe symptoms of depression and grief. They also found a moderate positive correlation between complicated grief scores and depression scores, a weak positive correlation between DIF scores and complicated grief scores, and a weak negative correlation between EOT and depression scores. In addition, the DIF component significantly predicted complicated grief scores, whereas DDF and EOT did not. In parallel with this, there are other supporting studies that have found that anxiety, depression and alexithymia are higher in patients diagnosed with PCBD (Sirlher Emir et al., 2022). In another study, the findings were observed to be contradictory. Deno et al. (2011) found that the correlation between alexithymia and complicated grief varied according to the severity of complicated grief; as the severity of complicated grief increased, the effect of alexithymia on grief decreased, and alexithymia had less effect on complicated grief compared to depression.

In another study that found that alexithymia may be associated with a more complicated grief experience, Deno et al. (2013) aimed to examine the effect of the severity of complicated grief and the time passed since the loss on the relationship between alexithymia and psychological distress. According to the results of their study, the DIF scores of the group with the high complicated grief scores two years after the loss were significantly higher than the non-bereaved group and the group with the low complicated grief scores six months after the loss.

In another research that assessed complicated grief reactions and conducted with two groups (psychosomatic group and healthy group) of Japanese women who lost their spouses or first-degree relatives, Nakao et al. (2005) found that the DIF scores of individuals in the psychosomatic group were higher than the healthy group, complicated grief reactions scores and DIF scores were positively correlated in the whole sample and also while DIF was positively correlated with complicated grief reactions scores, EOT was negatively correlated in the psychosomatic group.

In addition to studies examining the predictive role or association of alexithymia with grief reactions and pathological grief, there is also evidence suggesting that complicated grief may predict alexithymia (Calderon et al., 2019).

In grief research, studies not only focus on the loss of a loved one due to death but also include examinations related to health loss. Similar to the grief experienced after losing a loved one to death, alexithymia is also associated with grief reactions as a result of the loss of one's own health or the health of a relative (de la Rubia, 2015; Lai et al., 2014).

Lastly, Ogrodniczuk et al. (2005) conducted a study in which they analyzed whether the relationship between alexithymia and the outcome of group psychotherapy for complicated grief was mediated by the therapist's reactions towards the patient. They observed that especially high EOT and DDF were less positively related to therapy outcomes, patients with high alexithymia received fewer positive reactions from therapists, and the therapist's reactions mediated the relationship between alexithymia and therapy outcome. They found that this mediation relationship explained approximately one-third to half of the effect of alexithymia on psychotherapy.

#### **1.4. Purpose of This Research**

Research on conceptualization of alexithymia has been increasing in recent years, and its associations with various psychological concepts and disorders are being examined. Similarly, the literature on grief has a long history; however, the idea that grief can develop into a pathological condition has gained broader acceptance more recently. Although many factors are known to shape the grief process, there is still limited and inconclusive literature regarding the role of alexithymia, an emotion-related construct, as a potential predictor. As in many psychological conditions, identifying such predictors is important for guiding the course of therapy. Gaining a clearer understanding of alexithymia's role may help shape and improve the effectiveness of therapeutic interventions for individuals experiencing grief, which can be a complex and challenging process.

Although alexithymia has been a highly studied topic recently, there are very few studies that include the concept of grief. In addition to its potential contributions to therapeutic processes, this study aims to take another step to close the existing gap in the literature concerning the relationship between alexithymia and grief, and to provide guidance for future research. It is also expected to contribute to the understanding and treatment of both alexithymia and grief. In light of these objectives and reasons, the present study focuses and aims to examine the role of alexithymia as a predictor in the experience of grief.

The hypotheses of this study are as follows:

H<sub>1</sub>: Alexithymia scores (Toronto Alexithymia Scale) will positively predict the severity of negative grief reactions (Hogan Grief Reaction Checklist - Misery scale scores).

H<sub>2</sub>: Alexithymia scores (Toronto Alexithymia Scale) will negatively predict the severity of positive grief reactions (Hogan Grief Reaction Checklist - Personal Growth subscale scores).

H<sub>3</sub>: Alexithymia scores (Toronto Alexithymia Scale) will positively predict four dimensions (despair, panic behavior, detachment, disorganization subscales) of negative grief reactions (Hogan Grief Reaction Checklist - Misery scale scores).

## 2. METHOD

### 2.1. Participants

In this study, the ideal sample size was determined using G\*Power 3.1 software. When analyzing the ideal sample size, the parameters were set as effect size 0.15, power 0.95,  $\alpha$  error probability 0.05 and number of predictors 1. The required sample size based on these criteria was calculated as 89. However, the final sample consisted of 106 participants, aged between 18 and 60 years. According to DSM-5 TR, at least 12 months should have passed since the loss within the context of prolonged grief disorder (APA, 2022), but since normal grief experience rather than pathological grief was studied in this study, individuals who have experienced a loss due to death at least 6 months and at most 1 year ago were included in this study.

The participants' ages ranged between 18 and 65 years ( $M = 37.7$ ,  $SD = 11.1$ ) and 66 of these 106 participants were biologically female (62.3%). Participants' education levels, income rates, relationship status and who they live with are shown in Table 1. Within the scope of this study, participants who had lost a relative at least 6 months and at most 1 year ago were reached and the majority of the participants had experienced a loss 8 months ago (24.5%). The majority of the participants ( $n = 32$ ) lost their grandparent/child due to death (30.2%). There are 3 participants currently receiving psychiatric or psychological help, 3 participants who received such help in the past but are not currently receiving it, 4 participants currently using psychiatric or neurological medication, 6 participants who previously used such medication but are not using it now, and 6 participants who have been diagnosed with a psychiatric or psychological disorder.

**Table 2.1.**

*Demographic Characteristics of Participants*

Variables		N	%
Gender	Female	66	62.3
	Male	40	37.7
Education	Elementary	1	0.1
	Middle	0	0.0
	Highschool	10	9.4
	Bachelor's degree	75	70.8
	Master's/PhD degree	20	18.9
Income	Very low	1	0.1
	Low	8	7.5

	Middle	82	77.4
	High	15	14.2
	Very high	0	0.0
Relationship	Married	58	54.7
	Single	28	26.4
	Divorced	3	2.8
	Widowed	0	0.0
	In relationship	17	16.0
Live with	Family	86	81.1
	Relative	1	0.1
	Friend	1	0.1
	Partner	4	3.8
	Alone	11	10.4
	Institution, dormitory etc.	3	2.8

As it can be seen in Table 2 the majority (n= 46) of the participants lost their relatives due to illness/expected causes (43.4%), such as old age, chronic diseases (56.6%), and in total, the majority (n= 60) of the deaths mentioned were unexpected/sudden (56.6%). Participants in the study evaluated how old the deceased person died, how much they were affected by the death (Degree of influence), their relationship with the deceased person (Relationship) and how much social support they received during the grieving process (Social support).

**Table 2.2.**

*Descriptive Statistics of Participants' Losses*

Variables		N	%
Kinship	Spouse	0	0.0
	Parent	22	20.8
	3 <sup>rd</sup> degree relative	22	20.8
	Child	0	0.0
	Sibling	2	1.9
	Grandparent/child	32	30.2
	Cousin	5	4.7
	Partner	0	0.0
	Friend	9	8.5
	In-laws	8	7.5
Cause of death	Illness/Sudden	43	40.6
	Illness/Expected	46	43.4
	Traffic Accident	5	4.7

	Accident	1	0.1
	Suicide	7	6.6
	Violent	0	0.0
	Natural Disaster	0	0.0
Suddenness	Expected	46	43.4
	Unexpected	60	56.6

## 2.2. Measures

### 2.2.1. Demographic information form

This form includes questions on basic information such as age, gender, education level, relationship status, and economic level. In addition to these, there are questions related to the loss experienced within the scope of the subject of the study, such as kinship with the loss, how and when the person died, whether it was expected or sudden. Finally, history of psychiatric or psychological support and psychiatric or neurological medication use are questioned (Appendix 2).

### 2.2.2. The Twenty-Item Toronto Alexithymia Scale (TAS-20)

This scale, which is based on self-report and aims to measure the level of alexithymia, was developed by Bagby et al. (1994a, b). TAS-20, which contains 20 items in total, is a 5-point Likert type (1: I never agree, 5: I always agree). It includes 3 subscales which are Difficulty Identify Feelings (DIF) (7 items), Difficulty Describing Feelings (DDF) (5 items) and Externally-Oriented Thinking (EOT) (8 items).

Turkish standardization studies of the scale were conducted by Güleç et al. in 2009. In the Turkish adaptation, the internal consistency coefficient was 0.78 for total scale. Cronbach alpha values for the subscales were 0.80 for the DIF, 0.57 for the DDF and 0.63 for the EOT. In this study, which included 106 participants, the reliability analysis revealed that the Cronbach's alpha coefficient for the total scale was 0.75. The reliability analysis of the subscales showed that the Cronbach's alpha values were 0.77 for DIF, 0.56 for DDF, and 0.28 for EOT. Items 4, 5, 10, 18 and 19 are scored reversely. High scores indicate high alexithymia. It takes approximately 5-10 minutes to complete the scale. (Appendix 3).

### 2.2.3. Hogan Grief Reaction Checklist (HGRC)

The aim of this scale, developed by Hogan et al. in 2001, is to measure the grieving process in a multidimensional way. This scale, which contains 61 items and 6 subscales in

total, is a 5-point Likert-type scale (1: Does not describe me at all, 5: Describes me very well). These 6 subscales in the scale can be listed as follows: Despair, Panic Behavior, Blame-Anger, Detachment, Personal Growth and Disorganization. In a study conducted by Gamino et al. in 2000, the negative and positive effects of grief were scored separately on this scale. To assess negative effects, they named the 5 subscales (Despair, Panic Behavior, Blame-Anger, Detachment, Disorganization) as the HGRC Misery Scale and combined the sum of the scores into like it is a single scale. Personal Growth subscale score was used for evaluate the positive effects of grief.

The Turkish standardization of the scale was conducted by Yıldırım and Fıfılođlu in 2005. Cronbach's alpha value of the total scale was found to be 0.95. The internal consistency coefficients of the factors are between 0.74 and 0.87. In the reliability analysis conducted specifically for this study, the Cronbach's alpha coefficient for the total scale was found to be 0.95. The Cronbach's alpha values for the subscales were 0.90 for Despair, 0.90 for Panic Behavior, 0.75 for Blame and Anger, 0.87 for Detachment, 0.85 for Disorganization, and 0.87 for Personal Growth. It takes approximately 15-20 minutes to finish the scale. No single total score is obtained in the assessment of this scale since the Personal Growth subscale has a negative correlation with the other subscales. Each subscale can be evaluated individually or separately as the HGRC Misery Scale (sum of the scores of the 5 subscales) and the Personal Growth subscale (example items in Appendix 4). Permission to use the scale has been obtained, and its publication has been permitted only with the inclusion of a few sample items.

### **2.3. Procedure**

Following the approval of the study by the Bařkent University Research Ethics Committee (Appendix 5), participants were recruited. Data collection was conducted via the online survey platform Qualtrics. At the beginning of the survey, participants were presented with an informed consent form. Those who provided consent proceeded to complete the demographic information form, followed sequentially by the Toronto Alexithymia Scale (TAS-20) and the Hogan Grief Reaction Checklist (HGRC). Completion of the entire survey took approximately 15 to 20 minutes.

### **2.4. Research Design and Statistical Analysis**

The collected data were analyzed using IBM SPSS Statistics 25. In this study, alexithymia was treated as the predictor variable, while grief experience was the predicted variable. Stepwise multiple regression analysis was conducted to explore the predictive

power of alexithymia on various aspects of grief. Each subscale of the HGRC was analyzed as a separate predicted variable to investigate which dimensions of grief might be significantly associated with alexithymia. Additionally, the HGRC Misery Scale and Personal Growth subscale were analyzed as two distinct predicted variables. The aim of this analysis was to determine whether alexithymia significantly predicts the intensity or nature of the grief experience across different reactions.

### 3. RESULTS

Among the collected data, those who did not meet the criteria determined within the scope of the research, the time since their loss and the age range determined for the participants, were excluded from the sample. In addition, 1 participant who marked “illiterate” in the education status question in the demographic information form was excluded from the sample. Outliers were checked and 3 data were removed from the remaining participants who met the conditions required for the study. After these steps, 106 data from the people reached were included in the study.

While a total score can be obtained from the TAS-20 scale, the HGRC scale does not allow for the calculation of a total score due to the Personal Growth subscale being negatively correlated with the other subscales. For this reason, the Personal Growth subscale was scored separately, while the other five subscales—Despair, Panic Behavior, Blame and Anger, Detachment, and Disorganization—were grouped together and scored under the heading of the Misery Scale (Gamino et al., 2000). This scoring approach was adopted for use in the analyses.

#### 3.1. Descriptive Analysis

The data obtained from the participants through the demographic information form were analyzed. The minimum, maximum, mean and standard deviation values of data regarding how many losses participants experienced within the past 6 to 12 months, how many months had passed since the loss, how much the loss affected them, the age of the deceased person, how the participants evaluated their relationship with the deceased and how much social support they received during the grief are presented in Table 3.

**Table 3.1.**

*Descriptive Statistics of Losses*

Variable	Min	Max	Mean	SD
Number of losses	1	11	1.57	1.62
Time since death	6	12	8.68	1.98
Degree of influence	1	10	7.83	2.13
Age of deceased	1	102	65.72	21.24
Relationship	1	10	8.05	2.09

Social support	1	10	5.51	2.89
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*Note:* Min= Minimum; Max= Maximum; SD= Standard Deviation.

The maximum, minimum, mean, standard deviation, skewness and kurtosis values of all predictor and predicted variables are given in Table 4. In these descriptive analyses, the total score of the Toronto Alexithymia Scale (TAS-Total) and Difficulty Identifying feelings (DIF), Difficulty Describing Feelings (DDF) and Externally-Oriented Thinking (EOT) subscales were analyzed. The Hogan Grief Reaction Checklist, which was determined as a predicted variable, was analyzed as Misery Scale and Personal Growth since a single score could not be obtained in its scoring. Despair (Des), Panic Behavior (PB), Blame and Anger (BA), Detachment (Det) and Disorganization (Dis) subscales of the Misery Scale were also included. As shown in Table 4, the skewness and kurtosis values of all variables are within the required range (Tabachnik & Fidell, 2013).

**Table 3.2.**

*Descriptive Statistics of Variables*

Variable	Min	Max	Mean	SD	Skewness	Kurtosis
TAS - Total	23.00	69.00	45.82	9.10	0.21	-0.10
DIF	7.00	24.00	13.21	4.13	0.63	0.001
DDF	5.00	20.00	10.79	3.24	0.61	0.29
EOT	10.00	30.00	21.82	4.07	-0.39	0.12
Des	13.00	50.00	26.20	9.71	0.70	-0.32
PB	14.00	62.00	30.73	11.44	0.50	-0.28
BA	7.00	28.00	13.91	4.66	0.47	-0.38
Det	8.00	35.00	14.42	6.10	0.98	0.65
Dis	7.00	29.00	13.91	5.98	0.66	-0.49
PG	15.00	59.00	35.34	9.41	-0.06	-0.38
Misery	51.00	190.00	99.15	34.04	0.56	-0.51

*Note:* TAS – Total= Toronto Alexithymia Scale – Total scores; DIF= Difficulty Identifying Feelings; DDF= Difficulty Describing Feelings; EOT= Externally Oriented Thinking; Des= Despair; PB= Panic Behavior; BA= Blame and Anger; Det= Detachment; Dis= Disorganization; PG= Personal Growth; Min= Minimum; Max= Maximum; SD= Standard Deviation.

### 3.2. Correlation Analyses

In order to examine the relationship between gender, age, alexithymia and grief reactions, a Pearson product-moment correlation analysis was conducted between the TAS-20 and HGRC scales and their subscales (Table 5). Firstly, no significant correlations were observed between alexithymia and age or gender. However, women were found to experience significantly more intense overall negative grief reactions (misery scale) ( $r = .39$ ,  $p < .001$ ), despair ( $r = .39$ ,  $p < .001$ ), panic behavior ( $r = .42$ ,  $p < .001$ ), blame and anger ( $r = .27$ ,  $p < .01$ ), detachment ( $r = .22$ ,  $p < .05$ ), disorganization ( $r = .31$ ,  $p < .01$ ) and personal growth ( $r = .22$ ,  $p < .05$ ) compared to men. Moreover, age of the bereaved person was significantly and negatively correlated with the overall negative grief reactions (misery scale) ( $r = .25$ ,  $p < .01$ ), only the despair ( $r = .26$ ,  $p < .01$ ), blame and anger ( $r = .33$ ,  $p < .001$ ), and detachment ( $r = .23$ ,  $p < .05$ ) dimensions showed significant negative correlation with age.

Total alexithymia score showed a significant positive correlation with the misery scale of the grief reactions ( $r = .38$ ,  $p < .001$ ), despair ( $r = .25$ ,  $p = .009$ ), panic behavior ( $r = .31$ ,  $p = .001$ ), blame and anger ( $r = .40$ ,  $p < .001$ ), detachment ( $r = .53$ ,  $p < .001$ ), and disorganization ( $r = .34$ ,  $p < .001$ ). Conversely, it showed a significant negative correlation with personal growth during the grief process ( $r = -.20$ ,  $p = .038$ ). In conclusion, it was found that individuals with high levels of alexithymia tend to have more challenging grief reactions and that alexithymia has a negative impact on personal growth.

One of the components of alexithymia, difficulty identifying feelings, showed a significant positive correlation with the misery scale ( $r = .47$ ,  $p < .001$ ), despair ( $r = .37$ ,  $p < .001$ ), panic behavior ( $r = .41$ ,  $p < .001$ ), blame and anger ( $r = .48$ ,  $p < .001$ ), detachment ( $r = .56$ ,  $p < .001$ ), and disorganization ( $r = .33$ ,  $p < .001$ ) during the grief experience. However, its correlation with personal growth was not found to be significant. In summary, individuals who have greater difficulty identifying their feelings may experience more intense or challenging grief reactions during the grieving process.

Another component of alexithymia, difficulty describing feelings, was significantly and positively correlated with despair ( $r = .27$ ,  $p = .006$ ), panic behavior ( $r = .29$ ,  $p = .002$ ), blame and anger ( $r = .35$ ,  $p < .001$ ), detachment ( $r = .41$ ,  $p < .001$ ), disorganization ( $r = .29$ ,  $p = .003$ ), and the misery scale ( $r = .34$ ,  $p < .001$ ). No significant correlation was found between this component and the personal growth subscale. As a result, how the grief experience goes through is related to the person's ability to describe feelings. In this regard, difficulty in describing feelings is associated with the intensity of negative grief reactions.

Finally, the last component of alexithymia, externally oriented thinking, showed a significant positive correlation with detachment ( $r = .29, p = .003$ ) and a significant negative correlation with personal growth ( $r = -.25, p = .011$ ). However, no significant correlations were observed between externally oriented thinking and despair, panic behavior, blame and anger, disorganization, or the misery scale. As a result, if a person's thinking style is externally oriented, they can be expected to show detachment reaction during the grief process. In addition to this, it may have a negative impact on personal growth. No relationship was observed with other dimensions of grief reactions.

**Table 3.3.***Correlations among Variables*

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.
1. Gender	—												
2. Age	-.04	—											
3. TAS-Total	-.05	.02	—										
4. DIF	.07	-.01	.85**	—									
5. DDF	-.06	-.14	.78**	.62**	—								
6. EOT	-.12	.17	.75**	.40**	.33**	—							
7. Des	.39***	-.26**	.25**	.37**	.27**	-.02	—						
8. PB	.42***	-.18	.31**	.41**	.29**	.04	.81**	—					
9. BA	.27**	-.33***	.40**	.48**	.35**	.13	.80**	.74**	—				
10. Det	.22*	-.23*	.53**	.56**	.41**	.30**	.75**	.74**	.74**	—			
11. Dis	.31**	-.19	.34**	.33**	.29**	.19	.69**	.74**	.67**	.78**	—		
12. PG	.22*	.03	-.20*	-.01	-.17	.25*	.18	.22*	.06	.08	.03	—	
13. Mis	.39***	-.25**	.38**	.47**	.34**	.11	.92**	.93**	.86**	.88**	.85**	.15	—

*Note:* Gender= 0 for male, 1 for female; TAS – Total= Toronto Alexithymia Scale – Total scores; DIF= Difficulty Identifying Feelings; DDF= Difficulty Describing Feelings; EOT= Externally Oriented Thinking; Des= Despair; PB= Panic Behavior; BA= Blame and Anger; Det= Detachment; Dis= Disorganization; PG= Personal Growth; Mis= Misery \* $p < .05$ . \*\* $p < .01$

### **3.3. Inferential Statistics**

#### **3.3.1. Analysis of the predicting role of alexithymia in negative grief reactions (Misery Scale)**

A simple linear regression analysis was conducted to test whether alexithymia predicts grief reactions. In the first analysis, the total scores of the TAS-20 scale were included as the predictor variable and the Misery Scale as the predicted variable. According to the results of this regression analysis, alexithymia explained 14% of the variance ( $R^2 = .14$ ,  $F(1, 104) = 18.0$ ,  $p < .001$ ). Based on this result, alexithymia significantly and positively predicted the misery component of the grief experience ( $\beta = .38$ ,  $p < .001$ ). In conclusion, this analysis suggests that individuals with higher levels of alexithymia may experience a more challenging grieving process following a loss.

To examine whether alexithymia, measured through the subscales of Difficulty Identifying Feelings (DIF), Difficulty Describing Feelings (DDF), and Externally Oriented Thinking (EOT), predicts grief reactions, a stepwise multiple regression analysis was conducted.

First, a stepwise regression analysis was performed to test whether the alexithymia subscales predict individually the negative grief reactions measured by the Misery Scale. Only the DIF subscale was included in the model. Difficulty identifying feelings explained 22% of the variance ( $R^2 = .22$ ,  $F(1, 104) = 29.1$ ,  $p < .001$ ). According to the analysis, DIF significantly and positively predicted grief reactions ( $\beta = .47$ ,  $p < .001$ ). The other two subscales, DDF and EOT, did not make a significant contribution to the model and were excluded. As a result, it was concluded that individuals who have difficulty identifying their feelings may experience more intense negative grief reactions.

Hypothesis 1, positing that alexithymia would predict positively HGRC Misery Scale, was supported by the findings.

#### **3.3.2. Analysis of the predicting role of alexithymia in positive grief reactions (Personal Growth)**

A simple linear regression analysis was conducted in order to test whether alexithymia predicts personal growth negatively. According to this analysis, alexithymia explained 3.2% of the variance ( $R^2 = .03$ ,  $F(1, 104) = 4.41$ ,  $p = .038$ ). This result indicated that alexithymia significantly and negatively predicted personal growth during the grieving process ( $\beta = -.20$ ,  $p = .038$ ). Finally, people with high alexithymia may experience less personal growth throughout the grief process.

In the second analysis, a stepwise regression was conducted to test which subscales of alexithymia predict personal growth negatively. Only the EOT subscale was included in the model. Externally oriented thinking explained 5% of the variance ( $R^2 = .06$ ,  $F(1, 104) = 6.7$ ,  $p = .011$ ). According to the analysis, EOT significantly and negatively predicted personal growth ( $\beta = -.25$ ,  $p = .011$ ). The DIF and DDF subscales did not make a significant contribution to the model and were not included. As a result, individuals with a tendency toward externally oriented thinking may have more difficulty achieving personal growth during the grieving process.

Hypothesis 2, which posited that alexithymia scores would significantly and negatively predict the personal growth component, was supported.

### **3.3.3. Analysis of the predicting role of alexithymia in dimensions of negative grief reactions**

To examine which specific components of the grief reactions are predicted by alexithymia, separate simple linear regression analyses were conducted for each component of the HGRC Misery Scale in order to test Hypothesis 3 (Table 6). According to the regression analysis conducted to test whether alexithymia predicts despair experienced after loss, alexithymia explained 6% of the variance ( $R^2 = .06$ ,  $F(1, 104) = 7.12$ ,  $p = .009$ ). The results showed that alexithymia significantly and positively predicted despair ( $\beta = .25$ ,  $p = .009$ ). In conclusion, individuals with high alexithymia may feel more desperate during grief.

The regression analysis to test whether alexithymia predicts panic behavior during the grieving process showed that alexithymia explained 9% of the variance ( $R^2 = .09$ ,  $F(1, 104) = 10.9$ ,  $p = .001$ ). According to the analysis, alexithymia significantly and positively predicted panic behavior ( $\beta = .31$ ,  $p = .001$ ). This result suggests a relationship between high alexithymia and greater intensity of panic behaviors during grief.

The regression analysis conducted to test whether alexithymia predicts blame and anger during the grief experience showed that alexithymia explained 15% of the variance ( $R^2 = .15$ ,  $F(1, 104) = 19.7$ ,  $p < .001$ ). According to the results, alexithymia significantly and positively predicted blame and anger ( $\beta = .40$ ,  $p < .001$ ). Thus, individuals with high levels of alexithymia may experience more intense anger and blaming behaviors during grief.

The regression analysis conducted to test whether alexithymia predicts detachment during the grief experience showed that alexithymia explained 27% of the variance ( $R^2 = .27$ ,  $F(1, 104) = 40.0$ ,  $p < .001$ ). According to this analysis, alexithymia significantly and

positively predicted detachment ( $\beta = .53, p < .001$ ). As a result, higher levels of alexithymia may partially explain more intense experiences of detachment following loss.

The regression analysis conducted to test whether alexithymia predicts disorganization during grief showed that alexithymia explained 11% of the variance ( $R^2 = .11, F(1, 104) = 13.4, p < .001$ ). According to the results, alexithymia significantly and positively predicted disorganization ( $\beta = .34, p < .001$ ). Thus, individuals with higher alexithymia may be more disorganized in their grieving process following a loss.

Hypothesis 3, which states that alexithymia will predict the subscales of despair, panic behavior, detachment and disorganization of the misery scale in a positive and significant way, was supported. However, blame and anger, which were not expected to be predicted significantly by alexithymia, were also significantly and positively predicted.

**Table 3.4.**

*Simple linear regression analysis of alexithymia predicting subscales of misery scale*

Variable	<i>B</i>	SE	$\beta$	<i>t</i>	<i>p</i>	$R^2$	Adj. $R^2$
<i>Predicted variable: Despair</i>							
Constant	13.819	4.728		2.923	.004		
TAS-20	.270	.101	.253	2.669	.009	.064	.055
<i>Predicted variable: Panic behavior</i>							
Constant	12.981	5.477		2.370	.020		
TAS-20	.387	.117	.308	3.303	.001	.095	.086
<i>Predicted variable: Blame and anger</i>							
Constant	4.539	2.152		2.109	.037		
TAS-20	.204	.046	.399	4.436	<.001	.159	.151
<i>Predicted variable: Detachment</i>							
Constant	-1.760	2.608		-.675	.501		
TAS-20	.353	.056	.527	6.323	<.001	.278	.271
<i>Predicted variable: Disorganization</i>							
Constant	3.743	2.833		1.321	.189		
TAS-20	.222	.061	.337	3.656	<.001	.114	.105

*Not:* SE: standard error; Adj.  $R^2$ : Adjusted  $R^2$ .

## 4. DISCUSSION

This study was conducted to examine the predictive role of alexithymia on the experience of grief and grief reactions. This section presents a discussion of the findings obtained through analyses, considered within the framework of prior studies. First, the results of the correlation analysis, which aimed to explore the relationships among the main variables of interest, are discussed. This is followed by the findings from the regression analyses conducted to test the research hypotheses. These include simple regression analyses examining the predictive role of alexithymia on both positive and negative grief reactions, as well as stepwise multiple regression analyses focusing on the specific dimensions of alexithymia. Following that, a discussion of the clinical implications of the findings are presented. The final part of the section presents the study's strengths and limitations, followed by recommendations for future research.

### 4.1. Interpretation of the Findings

In order to examine the relationships among the variables, a correlation analysis was conducted including age, gender, alexithymia, its components, positive grief reactions, negative grief reactions, and its components. In contrast to the findings reported by Bagby et al. (1994a, 1994b) and Levant et al. (2009), which indicated that men tend to have higher levels of alexithymia compared to women, the present study found no significant gender differences in alexithymia within the sample. Similarly, although Mattila et al. (2006) reported that alexithymia levels increase with age, no significant association between age and alexithymia was observed in the current study. Nevertheless, the findings indicating that women experience more intense negative grief reactions than men after the loss of a loved one are consistent with previous research (Morina et al., 2010; Prigerson et al., 2002). In the current study, overall negative grief reactions were found to be negatively correlated with age; however, this association was not significant across all subdimensions. While this partially supports the findings of Burke and Neimeyer (2012), it contrasts with the results reported by Kersting et al. (2011). The existing literature presents conflicting evidence regarding the relationship between age and grief experiences, and the findings of present study are not strong enough to support clear conclusions.

The analysis revealed that alexithymia was associated with all grief reactions. It was found that alexithymia was positively and significantly correlated with all dimensions except for personal growth, which showed a significant negative correlation.

When examining the components of alexithymia, difficulty identifying feelings and difficulty describing feelings were positively associated with all grief reactions except personal growth. However, in contrast to expectations, the externally-oriented thinking component was only correlated with the detachment and personal growth dimensions, and surprisingly, these relationships were positive.

#### **4.1.1. Relationship between alexithymia and negative grief reactions (Misery Scale)**

In this study, alexithymia was found to significantly and positively predict negative grief reactions. The results indicate that individuals with higher levels of alexithymia may experience a more difficult grieving process. This finding aligns with the results of Nakao et al. (2005), who conducted a study with bereaved Japanese women and identified a positive relationship between alexithymia and grief reactions, suggesting a potential link between alexithymia and complicated grief. Similarly, Lai et al. (2014) emphasized that higher levels of alexithymia may increase the risk of developing prolonged grief. What distinguishes their study is its focus on caregivers of terminally ill patients, examining their experiences during the period before the loss of their loved ones, rather than after the bereavement.

Impairments in emotional awareness and difficulties in expressing emotions can weaken emotion regulation skills (Feldman Barrett et al., 2001). For effective and functional emotion regulation, it is essential that individuals are able to recognize and identify their emotions. (Gross, 1998). This is particularly critical during the grieving process, where the emotional and cognitive processing of the loss plays a key role in healing. Such difficulties may contribute to an increase in negative grief reactions. In their systematic review, Eisma and Stroebe (2021) found that poor emotion regulation skills and maladaptive strategies are associated with complicated grief. Furthermore, alexithymia has been shown to be positively associated with suppression—a strategy considered more maladaptive—and negatively associated with reappraisal, a more adaptive strategy (Laloyaux et al., 2015). Together, these results point to a link between high alexithymia and impaired emotional regulation, which may exacerbate the grieving experience.

This study proceeded within the scope of alexithymia's predictive role on grief reactions, considering alexithymia as a stable personality trait. However, there are also studies, such as Calderon et al. (2019), that examine whether experiencing loss predicts alexithymia. These studies have linked individuals' experiences of parental loss in early life with higher levels of alexithymia in adulthood. Moreover, they suggested that early losses,

through the mediating role of DIF and DDF, may lead to impairments in emotional processing and contribute to interpersonal distress, which in turn could result in difficulties coping with grief later in life. The finding that factors such as childhood trauma, abuse, or neglect play significant roles in the etiology of alexithymia, as highlighted by developmental models, supports this conclusion. Additionally, the presence of high levels of alexithymia in adulthood among these individuals may explain their potential to experience unresolved or prolonged grief related to childhood losses.

In this research, a stepwise multiple regression analysis revealed that among the components of alexithymia, difficulty identifying feelings was the strongest predictor of negative grief reactions. Supporting these findings, Nakao et al. (2005) also reported that DIF was particularly associated with maladaptive grief processes. Similarly, in a study conducted in Turkey, Kaya and Aydemir (2021) found that individuals with alexithymia exhibited more symptoms of complicated grief compared to those without, and they specifically identified DIF as a potential predictor of complicated grief. Different from these findings, Lai et al. (2014), in their research with caregivers of terminally ill patients, found a significant association between difficulty describing feelings and the risk of complicated grief.

#### **4.1.2. Relationship between alexithymia and personal growth**

Difficulties in recognizing, labeling, or interpret one's emotional experiences may hinder personal growth, which is a critical aspect of the grieving process. Findings from the current study suggest that individuals with high levels of alexithymia may experience impaired personal growth, which is a positive grief reaction. This finding is supported by Orejuela-Dávila et al. (2017), who indicated that alexithymia negatively predicted posttraumatic growth in individuals who had experienced highly stressful events. In order to cope adaptively with events involving intense stress, such as grief, individuals need to possess emotional skills that alexithymia may inhibit—specifically, the ability to be recognize and process emotions. Personal growth, as a response to grief, parallels posttraumatic growth in that it involves psychological improvement following a traumatic or distressing experience (Tedeschi & Calhoun, 2004).

Due to the components of alexithymia, it can impair emotional processing and regulation (Taylor, 2000), hinder the ability to making meaning of emotions and experiences, and disruption of introspective processes (Páez et al., 1999), factors that can explain its detrimental influence on personal growth. Furthermore, reappraisal, a strategy negatively

associated with alexithymia, has been shown to support personal growth; however, individuals with high levels of alexithymia may be less likely to adopt this strategy effectively. Moreover, alexithymia not only impairs intrapersonal emotional functioning but may also weaken interpersonal relationships, thereby adversely influencing negatively the grief process. High levels of alexithymia may be accompanied by insecure attachment styles and difficulties in forming and maintaining relationships. This, in turn, may hinder access to social support, which is crucial for psychological healing and growth during bereavement.

Deno et al. (2013), who examined the relationship between alexithymia, complicated grief, psychological distress, and time since loss, suggested a possible link between DIF and unresolved complicated grief. In the same study, they interpreted high levels of externally oriented thinking as a coping strategy in response to psychological distress and complicated grief. Similarly, Fisch (1989) proposed that individuals with high levels of alexithymia who have experienced loss may present with somatic symptoms and, consistent with the findings of Kaya and Aydemir (2021), may also mask depressive symptoms, in particular EOT. In light of these findings, although a tendency toward externally oriented thinking may function as a short-term coping strategy during the acute phase of grief, in the long term, it may hinder emotional processing and lead to more persistent negative grief reactions. Consistent with this interpretation, the results of the current study that was not conducted during the acute grief period, further support the predictive role of alexithymia components by showing that EOT negatively predicted personal growth in the stepwise regression analysis. Based on the evidence from Waller and Scheidt (2004) showing a negative correlation between externally oriented thinking and emotional awareness, this component may prevent the recognition and processing of emotions, as a result, individuals may experience limitation in personal growth following bereavement. Furthermore, difficulty identifying feelings may also intensify negative grief reactions by interfering with processes such as emotion regulation and emotional processing.

According to Stroebe and Schut's (1999) Dual Process Model, individuals experiencing bereavement need to oscillate in a balanced and flexible manner between loss-oriented stressors (related to grief itself) and restoration-oriented coping strategies (focused on adapting to life without the deceased) to process grief in a healthy way. From this perspective, alexithymia may interfere with healthy oscillation, potentially increasing negative grief reactions and hindering personal growth.

#### **4.1.3. Relationship between alexithymia and dimensions of negative grief reactions**

Several studies, including those by Taylor and Bagby (2013), have shown that alexithymia is negatively associated with positive emotions and positively associated with negative emotions (Lobb et al., 2010). In the current study, one of the negative affective grief reactions that despair, which encompasses feelings of sadness, loneliness, and helplessness, was found to be predicted by alexithymia. Individuals who struggle to identify and express their emotions may also have difficulty making sense of their loss and adapting to it. This may lead to more intense feelings of despair and sadness.

Furthermore, difficulties in recognizing and narrating emotional experiences can lead to increased rumination on negative emotions, disrupting the ability to regain psychological equilibrium for healing during bereavement, thereby intensifying the sense of despair. In addition, the finding that individuals with high levels of alexithymia are more likely to experience depression compared to those without alexithymia (Honkalampi et al., 2007) can explain the results of this study, especially when considering the overlap between symptoms of grief, depression and alexithymia. The inability to understand and express emotions, combined with reduced social interaction and support, may further contribute to heightened feelings of hopelessness, helplessness and despair in the aftermath of bereavement.

As a result of the analyses conducted in this study, it was found that alexithymia predicts panic behavior, which includes anxiety and somatic responses. The lack of emotional awareness inherent in alexithymia may create confusion and stress in individuals, and when they are unable to cope functionally, it may result in panic reactions. Additionally, considering the established relationship between alexithymia and somatic symptoms (Tominaga et al., 2013), it is possible that negative emotions that individuals cannot understand or express manifest physically. These physical reactions may not only contribute to a sense of panic, but somatic symptoms associated with high levels of alexithymia such as heart palpitations could also overlap with the physical sensations experienced during a panic episode. Furthermore, the 13.8% prevalence of alexithymia among individuals with panic disorder (Leweke et al., 2012) offers another explanation for this relationship. A lack of emotional awareness and clarity may trigger physiological responses, which in turn may lead to panic-related behaviors.

Research has also shown that individuals with high levels of alexithymia have difficulty distinguishing between emotions such as sadness and anger (Depont-Leclerc et al., 2018). They suggested that in situations that elicit intense sadness, such as grief, these

individuals may either suppress the experience of sadness altogether or, due to an inability to differentiate between sadness and anger, misinterpret their emotional state as anger. Contrary to expectations, the current study found that the blame and anger dimension, which includes feelings of irritation and unfairness, was significantly predicted by high alexithymia. Since blame and anger are emotions, they were not initially expected to be strongly related to alexithymia. However, this finding may be understood in the context of the relationship between alexithymia and maladaptive coping strategies, especially emotional suppression. The inability to process, identify, or express negative emotions after a loss may result in an increase in blame and anger. Unprocessed and unidentified emotions may lead individuals with high alexithymia to externalize their internal distress, potentially resulting in interpersonal conflict and a tendency to blame others or themselves.

As Nemiah and Sifneos (1970) noted, alexithymia is associated with deficits in social skills, avoidance of social interactions, and increased stress during interpersonal encounters. In a qualitative study, Depont-Leclerc et al. (2018) observed that participants with high levels of alexithymia tended to use suppression and evacuation strategies to cope with situations involving sadness. When examining participants' behaviors in distressing situations, they found that individuals often completely disconnected from their emotions by isolating themselves or withdrawing from others. Consistent with these findings, the current study revealed a significant relationship between alexithymia and the detachment reaction, which includes both social isolation and a disconnection with the deceased. Similarly, previous research also suggested that alexithymia may act as a coping mechanism or form of detachment following distressing events (Ahrens & Deffner, 1986; Kupchik et al., 2007). In light of these findings, it can be inferred that individuals with high levels of alexithymia may be more prone to experiencing detachment in response to stressful, painful, or traumatic situations such as bereavement. Even under normal circumstances, people with alexithymia are more likely to avoid social relationships, have difficulty expressing emotions, and rely on externally focused thinking styles. Therefore, following an emotionally intense experience like the loss of a loved one, it is expected that they may experience even greater levels of detachment.

These aspects of alexithymia may hinder emotional processing, the confrontation of loss, and engagement with the grieving process, potentially complicating the trajectory of grief. High levels of alexithymia may lead individuals to adopt maladaptive coping strategies, particularly those characterized by avoidance defenses (Preece et al., 2017). This avoidance can be associated with externally oriented thinking and difficulty in expressing

emotions, and may manifest as detachment. Avoidance in relationships and attachment due to alexithymia may further reinforce isolation and social withdrawal during bereavement, which in turn can prevent access to much-needed social support during the grieving process.

Difficulty in processing and labeling the intense, complex, and negative emotions experienced after a loss can lead to the adoption of more dysfunctional and maladaptive coping strategies during the grieving process, which may be associated with emotional disorganization. In this study, the disorganization dimension—which includes difficulties with concentration and memory—was found to be predicted by alexithymia during the grief process. Disorganization of emotions, thoughts, and behaviors, may become more pronounced in individuals with high levels of alexithymia, who already struggle to identify and express emotions. Impairments in the processing of emotions and thoughts related to the loss, the inability to fully comprehend or integrate the reality of the loss, and difficulties articulating this experience appear to be associated with alexithymia. Given the importance of emotional awareness and regulation, the individual's difficulty with these cognitive-emotional processes may contribute to an increase in disorganization.

According to the Dual Process Model, a disruption in the oscillation between loss- and restoration-oriented coping may stem from impairments in emotional processing. This, in turn, may result in more intense experiences of disorganization during grief, leading to confusion regarding self-identity, disoriented emotional responses, and deterioration in interpersonal relationships. Disorganization and detachment, as more cognitively anchored responses, appear to be strongly linked with disruptions in emotional processing. As de Tyche et al. (2010) stated, alexithymia may initially serve a protective function through emotional numbing or detachment following emotionally intense events such as loss; however, in the ongoing grief process, it may hinder emotional recovery and manifest as disorganization. Moreover, as alexithymia negatively impacts social sharing and interpersonal relationships, it may also contribute to the intensification of these two grief reactions. Therefore, alexithymia should be considered a significant personality trait in the therapeutic context.

#### **4.2. Clinical Implications**

Alexithymia and both pathological and normal grief share similarities in symptoms such as emotional dysregulation with depression. Due to these overlapping symptoms, distinguishing between these concepts is crucial for shaping effective therapy and treatment processes. Additionally, Grabe et al. (2008) suggested that the therapy outcomes for

individuals with major depression experiencing complicated grief could be negatively associated by alexithymia. This finding highlights the importance of differentiating these conditions and adjusting treatment accordingly. Therefore, being aware of potential differences in treatment response and related factors can help clinicians manage the therapeutic process more effectively.

There are studies on the relationship between alexithymia and grief across different cultures (Calderon et al., 2019; de la Rubia & Ávila, 2015; Deno et al., 2013; Lai et al., 2014; Nakao et al., 2005; Sırlıer Emir et al., 2022), and similar findings have been reported. While these studies play an important role in supporting the existence of this relationship, the fact that the samples often consist of specific demographic or clinical groups limits the generalizability of the results. Furthermore, these studies highlight the importance of considering cultural and contextual factors when addressing grief, which can enrich therapeutic interventions. Different cultures may have distinct traditional gender role norms or social expectations that influence a person's tendency to express emotions during the grieving process. Moreover, grief rituals vary across cultures and religions, which can affect grief reactions and personal growth. Taking these cultural aspects into account when designing therapy can be beneficial. In a grief-focused therapy may aim to foster a more adaptive grieving process, reduce maladaptive responses, improve interpersonal functioning, and support personal growth following loss.

In therapy, addressing emotion regulation, emotional processing, and maladaptive coping strategies within the framework of alexithymia can be efficient. A therapeutic approach that includes strategies to enhance emotional awareness, develop skills to express emotions, and regulate emotions will be beneficial. Focusing on the identification, expression, and restructuring of emotional experiences may support therapeutic progress. When working with alexithymia, it is also important to consider its potential impact on therapy outcomes and the therapist's reactions to the patients (Ogrodniczuk et al., 2005). A therapist's ability to adopt a broader perspective may positively influence the outcome.

When planning therapy in the context of alexithymia and grief, the choice between individual and group therapy should also be considered. McCallum et al. (2003), in a study with patients experiencing complicated grief, found that individuals with high levels of alexithymia may not benefit as expected from group therapy, due to difficulties in identifying and expressing emotions.

Although this study does not focus on pathological grief, existing research suggests that alexithymia may be a risk factor for complicated grief (Calderon et al., 2019; Deno et al., 2011; Kaya & Aydemir, 2021; Lai et al., 2014). Understanding the predictors of grief in terms of duration, intensity, and functionality, and exploring the role of alexithymia in this process will contribute to explaining the mechanisms behind grief reactions and can be considered as a risk factor.

#### **4.3. Strengths, Limitations and Future Directions**

The literature examining the relationship between alexithymia and grief is notably limited. Existing studies primarily focus on pathological grief (Deno et al., 2013; Kaya & Aydemir, 2021; Sırlıer Emir et al., 2022). One of the strengths of the present study is its focus on how alexithymia can influence normal grief. Hogan et al. (2001) argued that grief scales developed through interviews with bereaved individuals, rather than based solely on theoretical models, provide a more valid assessment of the nature of grief. The use of the Hogan Grief Reaction Checklist in this study, which was developed for research rather than diagnostic purposes, represents another strength by offering a more comprehensive evaluation of grief.

With this research, a step has been taken to fill the gap in the literature, as well as a step towards a better theoretical understanding, especially in the context of grief. Identifying how emotional expression, emotional awareness, and externally oriented thinking relate to specific grief reactions can enhance our understanding of grief mechanisms and predictors. This knowledge may also be beneficial in structuring therapy processes and treatment planning. Considering the impact of alexithymia on therapy outcomes, a clearer understanding of its psychological processes can support more effective interventions. Furthermore, recognizing alexithymia as a possible factor behind individuals' use of adaptive or maladaptive coping strategies may provide clinicians with valuable insight for guiding treatment.

This study also has certain limitations. Firstly, similar to many of the studies cited in this research, it adopts a cross-sectional design. To determine whether alexithymia is a stable trait contributing to more difficult grief or a temporary state triggered by stressors such as loss, longitudinal studies are needed. Another limitation is the use of self-report questionnaires. Measuring constructs like alexithymia, which involve difficulties in emotional awareness, through self-report tools may restrict the validity of the findings. Individuals may not accurately report their grief reactions or levels of alexithymia if they

have trouble identifying or describing their emotions. For this reason, future research could benefit from clinician assessments or biological measures to improve reliability.

Moreover, many existing studies have been conducted with clinical samples, restricted demographic groups, or within specific cultural contexts. Therefore, more comprehensive research is necessary. While this study serves as a step toward this and encouraging further research, its small sample size constitutes another limitation. Future studies with larger samples could make more substantial contributions.

Most studies on alexithymia and grief have been conducted in countries like Turkey and Japan, which share certain cultural characteristics. It is important to encourage research in more diverse cultural contexts and to take into account cultural norms regarding emotional expression, as these may also influence the grieving process.

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## APPENDICES

### APPENDIX 1: INFORMED CONSENT FORM

#### Bilgilendirilmiş Onam Formu

Sayın Katılımcı,

Bu çalışma Başkent Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Tezli Yüksek Lisans Programı öğrencisi Psk. Bilge Çakmak tarafından Doç. Dr. Elvin Doğutepe danışmanlığında yürütülmektedir.

Çalışmanın amacı aleksitiminin (duyguları tanımlamakta, tanımakta ve ifade etmekte zorluk çekme) ölüm sebebiyle bir yakını kaybeden kişilerin kayıp deneyimleri ile olan ilişkisini değerlendirmektir. Bu kapsamda 18-60 yaş arası, en az 6 ay ve en fazla 1 yıl önce bir yakını ölüm sonucu kaybetmiş olan kişilerin bu çalışmaya katılımına ihtiyaç duyulmaktadır. Yaklaşık 20 dakika sürecek olan bu çalışmadaki soruları eksiksiz, dürüst ve dikkatli doldurmanız beklenmektedir. Soruları cevaplarken sizi en çok etkileyen kaybınızı düşünerek cevaplamanız istenmektedir.

Çalışmaya katılım tamamen gönüllülük esasına dayanmaktadır. Katılımcılara ait bilgiler ve veriler anonim olarak kaydedilecek ve gizliliği korunacak, paylaşılmayacaktır. Çalışma sonunda katılımcı dosyaları gerekli şekilde yok edilecektir. Katılımcıların, istedikleri zaman araştırmayı yarıda bırakma hakları bulunmaktadır.

Araştırmanın konusu sebebiyle rahatsızlık verici sorular olabilir veya aklınıza başa çıkması/kabullenmesi zor düşünceler gelebilir. Çalışma sonunda rahatsızlık veya stres deneyimleyen katılımcılar destek alma ihtiyacı hissederseniz Başkent Üniversitesi Labirent Psikoloji Çalışmaları Merkezi'ne \*\*\*\*\*@baskent.edu.tr mail adresinden ulaşabilirler.

Çalışma hakkında daha fazla bilgi edinmek ya da soru sormak istiyorsanız b\*\*\*\*\*@gmail.com adresinden araştırmacıya ulaşabilirsiniz.

Formu okudum, anladım, çalışmaya gönüllü katılmayı,

- Kabul ediyorum.
- Kabul etmiyorum

## APPENDIX 2: DEMOGRAPHIC INFORMATION FORM

### Demografik Bilgi Formu

**1. Cinsiyet:**

- Kadın
- Erkek
- Diğer.....
- Belirtmek istemiyorum

**2. Doğum yılı: .....**

**3. Eğitim durumunuz: (en son mezun olduğunuz okul)**

- Okur-yazar değil
- Okur-yazar
- İlkokul
- Ortaokul
- Lise
- Üniversite
- Yüksek lisans/Doktora

**4. Ekonomik gelir düzeyinizi nasıl tanımlarsınız?**

- Çok düşük     Düşük     Orta     Yüksek     Çok yüksek

**5. İlişki durumunuz:**

- Evli
- Bekar
- Boşanmış
- Eşini kaybetmiş
- İlişkisi var
- Diğer.....

**6. Kimlerle birlikte yaşıyorsunuz?**

- Aile
- Akraba
- Arkadaş
- Partner
- Yalnız
- Yurt, kurum vb.

**7. En az 6 ay – en fazla 1 yıllık süre içerisinde ölüm sebebiyle kaç yakınınızı kaybettiniz? .....**

BURADAN SONRAKİ SORULARI BİRDEN FAZLA KAYIP YAŞADIYSANIZ KAYBININ SİZİ EN ÇOK ETKİLEDİĞİNİ DÜŞÜNDÜĞÜNÜZ KİŞİYİ VE ONUN ÖLÜMÜNDEN SONRAKİ SÜRECİ DÜŞÜNEREK YANITLAYINIZ.

**8. Kaybın sizi etkileme derecesi (0: Hiç etkilenmedim, 10: Çok fazla etkilendim)**

0-10 arası

**9. Kaybınızın üzerinden ne kadar süre geçti? (Ay olarak) .....**

**10. Kaybettiğiniz kişiyle olan yakınlığınızı belirtiniz.**

- Eş
- Anne-baba
- Çocuk
- Kardeş
- Dede, anneanne, babaanne, torun
- 3. derece akraba (amca, hala, dayı, teyze)
- Kuzen
- Sevgili
- Arkadaş
- Kayın (sıhri) hısımlar (kayınvalide, kayınpeder, baldız, görümce vb.)
- Diğer.....

**11. Ölüm sebebi:**

- Hastalık/Ani (Kalp krizi vb.)
- Hastalık/Beklendik (Yaşlılık, kronik hastalıklar vb.)
- Trafik kazası
- Kaza (İş/ev kazası vb.)
- İntihar
- Şiddet içerikli (terör, cinayet vb.)
- Doğal afet
- Diğer (belirtiniz) .....

**12. Kaybınızı beklendik mi yoksa ani bir kayıp olarak mı değerlendirirsiniz?**

- Beklenmedik/Ani
- Beklendik/Sıralı

**13. Kaybedilen kişinin yaşı.....**

**14. Kaybedilen kişi ile aranızdaki ilişkiyi nasıl değerlendirirsiniz? (1: çok kötü, 10: çok iyi)**

1-10

**15. Kaybınızdan sonra psikolojik veya psikiyatrik yardım aldınız mı?**

- Evet, şu an alıyorum.
- Evet, önceden aldım, şu an almıyorum.
- Hayır, almadım.

**16. Cevabınız evet ise herhangi bir tanı aldınız mı?**

- Hayır, almadım.
- Evet, aldım. (Belirtiniz: .....) )

**17. Düzenli olarak herhangi bir psikiyatrik veya nörolojik ilaç kullanıyor musunuz?**

- Evet şu an kullanıyorum.
- Evet, önceden kullanıyordum, şu an kullanmıyorum.
- Hayır, hiç kullanmadım.
- Evet ise adı.....

**18. Kaybınızdan sonra çevrenizden ne kadar sosyal destek aldığınızı düşünüyorsunuz? (1: Hiç, 10: Çok fazla)**

1-10 arası

### APPENDIX 3: TORONTO ALEXITYMIA SCALE

#### Toronto Aleksitimi Ölçeği – 20

Lütfen aşağıdaki maddelerin sizi ne ölçüde tanımladığını işaretleyiniz.

*Hiçbir zaman (1),..... , Her zaman (5)* olacak şekilde bu maddelere puan veriniz.

	Hiçbir zaman	Nadiren	Bazen	Sık sık	Her zaman
1. Ne hissettiğimi çoğu kez tam olarak bilemem.	1	2	3	4	5
2. Duygularım için uygun kelimeleri bulmak benim için zordur.	1	2	3	4	5
3. Bedenimde doktorların bile anlamadığı duyular oluyor.	1	2	3	4	5
4. Duygularımı kolayca tanımlayabilirim.	1	2	3	4	5
5. Sorunları yalnızca tanımlamaktansa onları çözümlmeyi yeğlerim.	1	2	3	4	5
6. Keyfim kaçtığımda, üzgün mü, korkmuş mu yoksa kızgın mı olduğumu bilemem.	1	2	3	4	5
7. Bedenimdeki duyular çoğu kez kafamı karıştırır.	1	2	3	4	5
8. Neden öyle sonuçlandığımı anlamaya çalışmaksızın, işleri oluruna bırakmayı yeğlerim.	1	2	3	4	5
9. Tam olarak tanımlayamadığım duygularım var.	1	2	3	4	5
10. İnsanların duygularını tanıması zorunludur.	1	2	3	4	5
11. İnsanlar hakkında hissettiğimi tanımlamak benim için zordur.	1	2	3	4	5
12. İnsanlar duygularım hakkında daha çok konuşmamı isterler.	1	2	3	4	5
13. İçimde ne olup bittiğini bilmiyorum.	1	2	3	4	5
14. Çoğu zaman neden öfkeli olduğumu bilmem.	1	2	3	4	5
15. İnsanlarla, duygularından çok günlük uğraşları hakkında konuşmayı yeğlerim.	1	2	3	4	5
16. Psikolojik dramalar yerine eğlence programları	1	2	3	4	5

izlemeyi yeğlerim.

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 17. İçimdeki duyguları yakın arkadaşlarıma bile açıklamak bana zor gelir.       | 1 | 2 | 3 | 4 | 5 |
| 18. Sessizlik anlarında bile, kendimi birisine yakın hissedebilirim.            | 1 | 2 | 3 | 4 | 5 |
| 19. Kişisel sorunlarımı çözerken duygularımı incelemeyi yararlı bulurum.        | 1 | 2 | 3 | 4 | 5 |
| 20. Film veya oyunlarda gizli anlamlar aramak, onlardan alınacak hazzı azaltır. | 1 | 2 | 3 | 4 | 5 |

## APPENDIX 4: HOGAN GRIEF REACTION CHECKLIST

### HOGAN YAS TEPKİLERİ TARAMA LİSTESİ

*Bu anket çocuğunuzun kaybından sonra sizde olabilecek duygu ve düşüncelerin listesinden oluşmaktadır. Lütfen her maddeyi dikkatlice okuyup, **bugünü de** kapsayacak şekilde geçtiğimiz **iki hafta boyunca** hissetmiş olduğunuzu en iyi tarif eden ifadenin yanındaki numarayı işaretleyin. Lütfen hiçbir maddeyi atlamayın.*

1. Beni hiçbir şekilde tanımlamıyor
2. Beni tam olarak tanımlamıyor
3. Beni oldukça iyi tanımlıyor
4. Beni iyi tanımlıyor
5. Beni çok iyi tanımlıyor

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. Umutlarım kırıldı.....                      | 1 | 2 | 3 | 4 | 5 |
| 14. Yüreğimde bir ağırlık hissediyorum.....    | 1 | 2 | 3 | 4 | 5 |
| 27. Sıkça korkuyorum.....                      | 1 | 2 | 3 | 4 | 5 |
| 53. Kontrolümü kaybedeceğimden korkuyorum..... | 1 | 2 | 3 | 4 | 5 |

## APPENDIX 5: ETHICAL APPROVAL

Evrak Tarih ve Sayısı: 04.02.2025-426886



1993

T.C.

### BAŞKENT ÜNİVERSİTESİ REKTÖRLÜĞÜ

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#### SOSYAL BİLİMLER ENSTİTÜSÜ MÜDÜRLÜĞÜNE

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Prof. Dr. Sadegül AKBABA ALTUN  
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Ek: Değerlendirme Formu

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21 Ocak 2025

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Bilgilerinize saygılarımızla sunarız.

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