IBN HALDUN UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF CLINICAL PSYCHOLOGY

DOCTORAL THESIS

THE APPLICATION OF ISLAMICALLY INTEGRATED CHAIR-WORK TECHNIQUES FOR UNFINISHED BUSINESS IN PATIENTS WITH PROLONGED GRIEF

FEYZANUR TAŞTEKNE KARTAL

THESIS ADVISOR
ASSIST. PROF. TAHA BURAK TOPRAK

ISTANBUL, 2025

IBN HALDUN UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF CLINICAL PSYCHOLOGY

DOCTORAL THESIS

THE APPLICATION OF ISLAMICALLY INTEGRATED CHAIR-WORK TECHNIQUES FOR UNFINISHED BUSINESS IN PATIENTS WITH PROLONGED GRIEF

by
FEYZANUR TAŞTEKNE KARTAL

A thesis submitted to the School of Graduate Studies in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Psychology

THESIS JURY MEMBERS
ASSIST. PROF. TAHA BURAK TOPRAK (THESIS ADVISOR)
PROF. MEDAİM YANIK
PROF. VAHDET GÖRMEZ
ASSOC. PROF. BURCU UYSAL
ASSIST. PROF. DİLRUBA SÖNMEZ

ISTANBUL, 2025

ACADEMIC HONESTY ATTESTATION

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Full Name: Feyzanur Taştekne Kartal

Signature:

ÖZ

UZAMIŞ YAS YAŞAYAN DANIŞANLARDA BİTMEMİŞ İŞLER İÇİN İSLAMİ TEMELLİ BOŞ SANDALYE MÜDAHALESİNİN UYGULANMASI

Taştekne Kartal, Feyzanur
Klinik Psikoloji Doktora Programı
Öğrenci No.: 204059001
Open Researcher and Contributor ID (ORC-ID): 0000-0002-8660-2736
Ulusal Tez Merkezi Referans No.: 10518068

Tez Danışmanı: Dr. Öğr. Üyesi Taha Burak Toprak
Aralık 2025, 125 Sayfa

Bu araştırmanın amacı, yas sürecinde ortaya çıkan bitmemiş işler gerilimini azaltmayı hedefleyen Geleneksel İslami Temelli Psikoterapi (Traditional Islamically Integrated Psychotherapy – TIIP) Yas Protokolü'nü geliştirmek ve bu müdahalenin uzamış yas yaşayan Müslüman yetişkinlerdeki etkinliğini değerlendirmektir. Protokolün hem kuramsal temelleri hem de klinik uygulanabilirliği deneysel tasarımla incelenmiştir. Çalışma, süreç–sonuç tasarımı olarak yapılandırılmış, katılımcılar arasında eş zamanlı olmayan çoklu başlama düzeyi densysel deseni kullanılarak yürütülmüş, beş fazdan oluşmaktadır: (1) başlama düzeyi, (2) empatik uyum (1. ve 2. seans), (3) İslami temelli boş sandalye müdahalesi (3. ila 5. seanslar), (4) bilişsel pekiştirme ve manevi davranış planı (6. ve 7. Seans) ve (5) takip aşaması (müdahaleden bir ay sonra). Çalışma dokuz katılımcıyla (n = 9) tamamlanmıştır. Katılımcılar 2, 4 veya 6 haftalık başlama düzeylerine seçkisiz olarak atanmış; bunu yedi seanstan oluşan 50 dakikalık yüz yüze bireysel psikoterapi takip etmiştir. TIIP Yas Protokolü erken dönem İslam alimleri Kindi, Razi ve İbn Sina'nın öğretilerini duygu odaklı tekniklerle entegre ederek bütüncül ve daha sağlıklı bir yas sürecini kolaylaştırır. Analizlerde görsel inceleme, Tau-U etki büyüklüğü, Wilcoxon testi ve Jacobson–Truax Güvenilir Değişim İndeksi uygulanmıştır. Görsel analizler, başlama düzeylerinin tüm katılımcılarda kararlı olduğunu ve bitmemiş işler geriliminde üçüncü oturumdan itibaren belirgin ve sürekli düşüşler görüldüğünü göstermiştir. Tau-U analizleri büyük etkilere işaret etmiş; dokuz katılımcının yedisinde klinik olarak anlamlı iyileşme saptanmıştır. Wilcoxon testleri

bitmemiş işler geriliminde öntest–sontest ve öntest–izlem karşılaştırmalarında anlamlı ve güçlü azalmalar göstermiştir. Bitmemiş işler gerilimi açısından RCI analizinde iki katılımcıda güvenilir iyileşme saptanmıştır. İzlem değerlendirmeleri yas bilişlerinde anlamlı bir azalma olduğunu göstermiş; uzamış yas belirtilerinde ise istatistiksel anlamlılığa ulaşmamakla birlikte orta düzeyde iyileşme elde edilmiştir. Bu bulgular birlikte değerlendirildiğinde, TIIP Yas Protokolü'nün bitmemiş işler gerilimini azaltmada etkili, sürdürülebilir ve klinik açıdan anlamlı bir müdahale olduğu görülmektedir.

Anahtar Kelimeler: Bitmemiş İşler, Çoklu Başlama Düzeyi Deseni, Müslüman, TIIP, Uzamış Yas Bozukluğu, Yas.

ABSTRACT

THE APPLICATION OF ISLAMICALLY INTEGRATED CHAIR-WORK TECHNIQUES FOR UNFINISHED BUSINESS IN PATIENTS WITH PROLONGED GRIEF

Taştekne Kartal, Feyzanur
PhD in Clinical Psychology
Student ID: 204059001
Open Researcher and Contributor ID (ORC-ID): 0000-0002-8660-2736
National Thesis Center Reference No.: 10518068

Thesis Supervisor: Assist. Prof. Taha Burak Toprak
December 2025, 125 Pages

This study aims to develop the Traditional Islamically Integrated Psychotherapy (TIIP) Grief Protocol, designed to reduce unfinished business tensions emerging in the bereavement process, and to evaluate its effectiveness among Muslim adults experiencing prolonged grief. The protocol's theoretical foundations and clinical applicability were examined experimentally. The study was structured as a process–outcome, using a nonconcurrent multiple-baseline experimental design across participants, comprising five phases: (1) baseline, (2) Empathic attunement (1st & 2nd sessions), (3) Chair-work intervention (3rd – 5th sessions), and (4) Cognitive consolidation and spiritual behavioral plan (6th & 7th sessions), and (5) follow-up phase (one-month post-intervention). The study was completed with nine participants (n = 9). Participants were randomly assigned to 2-, 4-, or 6-week baseline phases, followed by 50-minute face-to-face individual psychotherapy totaling seven sessions. TIIP Grief Protocol integrating insights from early Islamic scholars Al-Kindi, Al-Razi, and Ibn Sina with emotion-focused techniques to facilitate holistic and healthier bereavement. Analyses included visual inspection, Tau-U effect size estimation, Wilcoxon signed-rank tests, and the Jacobson–Truax Reliable Change Index. Visual analyses revealed stable baseline patterns across all participants and clear, consistent reductions in unfinished business tension beginning in Session 3. Tau-U analyses revealed significant effects, with 7 of 9 participants showing clinically meaningful

improvement. Wilcoxon tests indicated significant and robust reductions in unfinished business from pre- to post-treatment and from pre-treatment to follow-up. Regarding unfinished business tension, RCI analysis showed reliable improvement for two participants. Follow-up assessments indicated significant reductions in grief cognitions, suggesting beneficial cognitive restructuring processes. Although decreases in prolonged grief symptoms did not reach statistical significance, they reflected moderate improvement. Taken together, the findings indicate that the TIIP Grief Protocol is a practical, sustainable, and clinically meaningful intervention for reducing unfinished business tension among bereaved Muslims.

Keywords: Grief, Multiple-Baseline Design, Muslim, Prolonged Grief Disorder, TIIP, Unfinished Business.

DEDICATION

To ***Leyla Umay***,
who patiently waited for me to play with her and whose affection continually motivated me to complete this work.

To ***Abdulkerim***,
who has always stood by my side and supported me wholeheartedly through every moment of my Ph.D. journey.

To ***my parents, Emine and Yavuz Selim***,
whose unwavering support accompanied me throughout my long educational path.

ACKNOWLEDGEMENT

In the Name of God, Most Merciful, Most Compassionate.

I hope this study will be accepted as the zakat of my knowledge by Allah, He is The All-Knowing (*Al-Âleem*), The Most Subtle (Al-Latîf), and the Inflicter of Death (Al-Mumeet).

Throughout my doctoral education, my valued mentor and supervisor, Assistant Prof. Hooman Keshavarzi, never withheld his support or expertise—from the earliest idea stage of my dissertation, through the data collection process, and ultimately to the moment of my defense. I extend my deepest gratitude to him. With his support, I was always able to breathe amid this demanding, arduous doctoral journey.

I would also like to acknowledge the valuable contributions of my committee members. I sincerely thank my dissertation advisor, Assistant. Prof. Taha Burak Toprak, as well as Prof. Medaim Yanık, Prof. Vahdet Görmez, and Assoc. Prof. Burcu Uysal and Assistant. Prof. Dilruba Sönmez, whose constructive input throughout the process helped shape and strengthen this work.

I am especially grateful to my doctoral colleagues and fellow clinicians, Ph.D. candidates Mehmed Seyda Tepedelen and İlknur Aytemür Mneimneh, who shared the responsibility for the clinical sessions with me and shouldered this process alongside me. I also owe heartfelt thanks to my research assistants, Psychologist Asude Zeynep Erbay and Psychologist Sevde Karakuş, whose support made this multi-layered and often difficult-to-track research process far more manageable.

I want to express my sincere appreciation to my esteemed professors who generously shared their knowledge and experience throughout my doctoral education: Prof. Medaim Yanık, Prof. Ömer Mücahit Öztürk, Dr. Nilgün Öcal, and Assistant. Prof. Hooman Keshavarzi, Assoc. Prof. Burcu Uysal, Assist. Prof. Taha Burak Toprak, Assoc. Prof. Hasan Turan Karatepe and Prof. Vahdet Görmez. From each of them, I learned invaluable lessons that I will carry with me throughout my professional life.

During my internship—one of the most instructive parts of my doctoral training—I had the privilege of working with an exceptional group of talented colleagues. For me, İPAM was not only an internship site that created space for my professional development, but also a center where I experienced and learned many things. I owe my most sincere thanks to all my friends with whom I took courses in both my

academic and clinical training—those with whom I learned, and from whom I knew—and with whom we supported one another throughout this painful journey. In particular, Dilruba Sönmez, Mehmed Seyda Tepedelen, Esma Tüzgen, İlknur Aytemür Mneimneh, Meryem Kahramanlar, Sümeyye Köten Güçlü, Enes Kaban, and Elif Akyüz: I am grateful you were there, and thankful you are in my life. And I would also like to thank Büşra Kavla, with whom we ran the final stretch of this long journey together, for the emotional and instrumental support she provided. I also thank Hilal Demirci, Rabia Beksöz, and Kübra Kayaokay, who consistently supported me in my daily work at İPAM and helped ease difficulties along the way.

I would also like to thank my dear friends—whom I met during my master's training at Ibn Haldun University and with whom I have remained closely connected—along with my valued colleagues who have never withheld their support or knowledge: Elif Bestenigar Mert, Esra Altınışık, Yağmur İskit, Dilara Sürü, and Ceren Kaban. I am especially grateful to my friend Sevde Kurt Akkoyun, with whom I became a mother around the same time, for her emotional support throughout this process.

I cannot find words sufficient to thank my family—my mother, my father, and my sister—who have supported me unconditionally through every phase of my life, in every rise and fall, never hesitating to show their love, and who constitute the most crucial foundation enabling me to write these lines today. Throughout my education, they always told me, "Keep going, we are behind you," and they lived by those words. I also extend my sincere thanks to my mother-in-law, father-in-law, and sister-in-law, who were consistently supportive throughout this journey.

I am deeply grateful to my mother Emine, my sister Ayşe, my mother-in-law Müminet, and my sister-in-law Nisanur, who played with my daughter and kept her heart content so that I could reach the mental space needed to complete my dissertation. You have always shown me what it means to be a family.

To my daughter —Leyla'yım Umay'ım— who has warmed and brightened my heart more than the sun from the moment she entered my life, who has made my days more beautiful, and who has been my most significant source of motivation in finishing this dissertation: thank you. As for my beloved husband, with whom I met while preparing my dissertation proposal, and who has supported me in every circumstance and condition ever since, no words will ever be enough. At times, he stayed up through the night with me; when I was exhausted, he lifted me; and even in my most hopeless

moments, he helped me find a way forward. Thank you so much—thank you for being you, Kerim.

…

Life is a multi-variable journey between birth and death—one that does not conform to any mathematical formula. As endearing as its beginning may be, its ending can be just as full of sorrow. Throughout this dissertation, I had the honor of accompanying individuals in their lives and of being entrusted with their deepest pains. I extend my heartfelt gratitude to my valued participants who shared their grief with me. From each of them, I learned so much about longing, pain, and love.

…

Death is an experience filled with pain. Yet, despite this pain, some remain standing—and who teach us what it means to stay standing—greetings to the people of Palestine and East Turkistan.

"Death—how far it is from us, and how near.
We have tasted immortality; what can death do to us?"
Erdem Beyazıt

Feyzanur TAŞTEKNE KARTAL
İSTANBUL, 2025

TABLE OF CONTENTS

ÖZ ..... **iv**
ABSTRACT ..... **vi**
DEDICATION ..... **viii**
ACKNOWLEDGEMENT ..... **ix**
TABLE OF CONTENTS ..... **xii**
LIST OF TABLES ..... **xv**
LIST OF FIGURES ..... **xvi**
LIST OF SYMBOLS AND ABBREVIATIONS ..... **xvii**
CHAPTER I INTRODUCTION **1**
1.1. Statement of the Problem and the Significance of the Study 2
1.2. Research Questions 4
CHAPTER II LITERATURE REVIEW **6**
2.1. Conceptualizing Grief 6
2.1.1. Foundational Theories of the Grieving Process 10
2.1.1.1. Psychoanalytic Theory–Sigmund Freud 10
2.1.1.2. Attachment Theory–John Bowlby 12
2.1.1.3. The Five Stage Model–Elisabeth Kübler-Ross 13
2.1.2. Contemporary Theories of the Grieving Process 15
2.1.2.1. The Dual Process Model–Stroebe and Schut 15
2.1.2.2. Meaning Making–Robert A. Neimeyer 15
2.1.3. Conceptualizations of Grief in Islamic Texts 16
2.1.3.1. Grief in Early Islamic Thought 18
2.1.3.1.1. Al-Kindî (Alchindus) 18
2.1.3.1.2. Abu Bakr Al-Razi (Rhazes) 21
2.1.3.1.3. Ibn Sînâ (Avicenna) 22
2.2. Grief as Psychopathology 23
2.3. The Role of Unfinished Business in Prolonged Grief 29
2.4. Chair-Work Dialogue 30
2.4.1. Resolving Unfinished Business via Empty Chair-Work Dialogue 32
2.5. Theoretical Framework: Traditional Islamically Integrated Psychotherapy 36
2.5.1. TIIP Protocol for Unfinished Business in Prolonged Grief 40
2.5.2. TIIP Empty Chair-Work Intervention 42

2.5.3. Working With Emotions 43
2.6. Hypotheses of the Present Study 46
CHAPTER III METHOD 48
3.1. Study Design 48
3.2. Participants 49
3.3. Practitioners 50
3.4. Procedure 51
3.4.1. The TIIP Grief Protocol 51
3.4.1.1. Empathic Attunement Phase 54
3.4.1.2. TIIP Chair-Work Phase 55
3.4.1.3. Cognitive Consolidation & Spiritual Behavioral Plan Phase 58
3.4.2. Data Collection 59
3.5. Fidelity 60
3.6. Measures 61
3.6.1. Intake Form and Socio-Demographic Questionnaire 61
3.6.2. The Unfinished Business in Bereavement Scale–Brief (UBBS-Brief) 61
3.6.3. Prolonged Grief Disorder-13 Scale (PG-13) 62
3.6.4. Grief Cognitions Questionnaire (GCQ) 62
3.6.5. Patient Health Questionnaire-9 (PHQ-9) 62
3.6.6. Generalized Anxiety Disorder-7 (GAD-7) 63
3.6.7. The Client Emotional Arousal Scale III (CEAS-III) 63
3.6. Data Analysis 65
3.7.1. Visual Inspection 65
3.7.2. Nonparametric Tests 65
3.7.3. Effect Size Estimation 65
3.7.4. Clinical Significance 66
CHAPTER IV RESULTS 67
4.1. Participant's Characteristics 67
4.2. Baseline Data 71
4.3. Visual Analysis of Unfinished Business Tension 73
4.4. Tau-U Results 75
4.5. Emotional Arousal During Sessions 77
4.6. Wilcoxon Test Results 80
4.7. Reliable Change Index (RCI) 82

CHAPTER V DISCUSSION **85**
5.1. Overview of Findings 85
5.2. Chair-Work Effects on Unfinished Business 85
5.3. Emotional Arousal 89
5.4. Reduction in Prolonged Grief Symptoms 93
5.5. Cognitive Adaptation 94
5.6. Broader Psychological Well-Being 96
5.7. Limitations 97
5.8. Implications and Future Directions 98
CHAPTER VI CONCLUSION **100**
REFERENCES **102**
APPENDICES **120**
APPENDIX A ETHICS COMMITTEE PERMISSION 120
APPENDIX B STEP-BY-STEP TIIP GRIEF PROTOCOL 121
CURRICULUM VITAE **124**

LIST OF TABLES

Table 2.1. Process of Change in TIIP 37
Table 3.1. Study Design 49
Table 3.2. Summary Table of Psychotherapy Process 53
Table 3.3. Administration Time of the Questionnaires 60
Table 3.4. Summary of Measures Used in the Study 64
Table 4.1. Sociodemographic and Clinical Characteristics of Participants 68
Table 4.2. Participants Characteristics–General View 70
Table 4.3. Baseline Scores for Participants 72
Table 4.4. Baseline Trend Tests (Kendall's τ) for UBBS and Decision on Parker Correction 75
Table 4.5. Participant-Level Tau-U for Unfinished Business (UBBS) with 90% Confidence Intervals 76
Table 4.6. Descriptive Statistics for CEAS–III Scores Across Sessions 77
Table 4.7. Linear Mixed-Effects Model Predicting CEAS–III Scores from Session 80
Table 4.8. Wilcoxon Signed-Rank Test Results 81
Table 4.9. Reliable Change Index (RCI) and Clinical Significance (Jacobson & Truax Method) 83
Table B.1. Step-by-Step TIIP Grief Protocol 121

LIST OF FIGURES

Figure 2.1. TIIP Model for Internal Human Psyche 39
Figure 2.2. Optimal Range for Grief Processing in TIIP 42
Figure 2.3. Emotional Transformation Process..... 46
Figure 3.1. Participant Flow Diagram..... 50
Figure 3.2. Example of the Components of the Resolution Model in the Third Phase57
Figure 4.1. Participants' Baseline Phase Scores 72
Figure 4.2. Weekly Unfinished Business Rating Scores Across Baseline, Treatment, and One-Month Follow-Up..... 74
Figure 4.3. Individual Participant Trajectories of CEAS–III Scores Across Sessions78
Figure 4.4. Group-Level CEAS–III Trend Across Sessions. 79
Figure 5.1. Grouped CEAS Scores Per Session..... 91

LIST OF SYMBOLS AND ABBREVIATIONS

CBT	Cognitive Behavioral Therapy
CEAS	Client Emotional Arousal Scale
CGT	Complicated Grief Therapy
CI	Confidence Interval
CSG	Complicated Spiritual Grief
DSM	Diagnostic and Statistical Manual of Mental Disorders
EFT	Emotion Focused Therapy
GAD	Generalized Anxiety Disorder
GCQ	Grief Cognitions Questionnaire
ICD	International Classification of Diseases
İPAM	Ibn Haldun University Center for Psychotherapy Research
JT	Jacobson-Truax
M	Average
MDD	Major Depressive Disorder
MDN	Median
N	Sample Size
PGD	Prolonged Grief Disorder
PG-13	Prolonged Grief Disorder-13 Scale
PGDT	Prolonged Grief Disorder Therapy
PMEs	Primary Maladaptive Emotions
PHQ	Patient Health Questionnaire
PTSD	Posttraumatic Stress Disorder
RCBT	Religious Cognitive Behavioral Therapy
RCI	Reliable Change Index
SD	Standard Deviation
ST	Schema Therapy
TIIP	Traditional Islamically Integrated Psychotherapy
UBBS	The Unfinished Business in Bereavement Scale

CHAPTER I

INTRODUCTION

This study aims to develop and examine the effectiveness of Traditional Islamically Integrated Psychotherapy (TIIP) Grief Protocol for addressing unfinished business in patients with prolonged grief. While many bereaved individuals gradually adjust to the death of a loved one, a small yet significant number develop severe psychological difficulties (Prigerson et al., 2021). Research shows that those who have lost a loved one face a heightened risk of developing psychopathology in the first year after bereavement compared to non-mourners (Chen et al., 2020; Prigerson et al., 2009, 2021; Szuhany et al., 2020). Over the past few decades, studies have revealed that a substantial portion of grieving individuals experience persistent difficulties that exceed expected social, cultural, or religious norms.

With the inclusion of Prolonged Grief Disorder (PGD) in the DSM-5-TR (American Psychiatric Association, 2022), prolonged grief has been defined as grief lasting longer than 12 months in adults or 6 months in children, causing clinically significant impairment. Approximately 7–10% of bereaved adults experience persistent PGD symptoms (Szuhany et al., 2020). Among children and adolescents, around 5–10% develop depression, posttraumatic stress disorder (PTSD), and/or PGD following bereavement (Melhem et al., 2013). Misdiagnoses were a common issue in the past because of the absence of the grief-specific diagnosis, even though only a small group of grievers suffer from psychopathology (Prigerson, Boelen, et al., 2021).

Unfinished business is one of the most crucial risk factors for severe PGD, which is defined as incomplete, unexpressed, or unresolved relational problems with the lost one (Boelen et al., 2006; Cesur-Soysal & Durak-Batigün, 2020; Holland et al., 2014). According to Klingspon et al. (2015), nearly half of the bereaved individuals (43%) show some level of unfinished business tension. Higher levels of unfinished business

tension are associated with raised psychological distress and maladaptive grief expressions.

Within the framework of Traditional Islamically Integrated Psychotherapy (TIIP), unfinished business is conceptualized as an emotionally charged problem (Keshavarzi & Keshavarzi, 2020). Processing unfinished business in TIIP sessions helps patients resolve emotional conflicts, replace maladaptive emotions with adaptive ones, fulfill unmet needs, and create new meaning (Keshavarzi & Keshavarzi, 2020). Indeed, finding meaning in loss is associated with healthier grieving, making meaning-oriented techniques especially effective in grief therapy (Holland & Neimeyer, 2010). A systematic review further highlights that spirituality and religious practices strongly influence the expression of grief (De Stefano et al., 2020). Despite this, no faith-based intervention programs explicitly designed for grieving Muslims currently exist.

1.1. Statement of the Problem and the Significance of the Study

Grief is characterized by intense emotional suffering, a yearning or longing for the deceased, a sense of shock or shock at the loss, and difficulty in moving on after the loss (Papa et al., 2014). Loss of a loved one is an unavoidable, universal life experience, although it is also one of the most stressful (Holmes & Rahe, 1967). According to Prigerson, Kakarala et al. (2021), individuals who have experienced the loss of a loved one have a higher risk of developing psychopathology in the first year after bereavement, including an increased risk of self-harm and a higher risk of suicide. This group is also susceptible to a high degree of morbidity and mortality (Prigerson et al., 2009).

From an Islamic perspective, from the grieving person's perspective, death is seen as a natural part of the human lifecycle (Davoudi, 2022), including the soul's transfer from this world to the afterworld (Hedayat, 2006). To better explain the mourning process, several theories have been proposed in Western literature (e.g., Bowlby, 1980; Freud, 1917; Kübler-Ross, 1969; Stroebe & Schut, 1999). Nevertheless, they largely ignore socio-cultural variations outside of the bereavement of White people in Europe or North America (Beckett & Dykeman, 2017). Although it is known that religion and belief have a vital role in the mourning experience, there are no intervention programs

tailored explicitly for grieving Muslims that utilize a faith-based approach reported in the literature.

The importance of this research lies in its ability to help bridge a significant gap in the existing literature by addressing the unique cultural and religious needs of Muslim individuals in therapeutic settings. Muslims often avoid seeking psychotherapy due to concerns that mainstream psychotherapy approaches do not provide treatment within a religious or spiritual context (Amri & Bemak, 2013). This makes it difficult to connect with and trust therapists' treatment goals (Inayat, 2007). However, recent research indicates significant progress in integrating spirituality and religiosity into clinical practice over the last few decades (Richards et al., 2015). Haque and his colleagues (2016) examine research trends in Islamically integrated psychotherapy and highlight that religious and spiritual healing practices are essential for effective treatment and healing in mental health, and incorporating these perspectives into clinical practice has proven to be effective in treating various psychosocial issues.

In an Islamic context, healing is understood as a comprehensive conception of health in which mental, emotional, physical, and spiritual well-being are inextricably linked (Rassool, 2015). In clinical settings, many Muslim psychologists question the utilization of Western psychological approaches for helping Musli patients in Eastern countries. This skepticism arises due to the difficulty in generalizing Eurocentric perspectives to other cultures (Azuma, 1984) and the tendency to overlook the transcendental aspects of human beings (Badri, 1979; Haque, 1998)

On the other hand, some mainstream psychotherapy theories are adapting religious-based approaches to accommodate religiously adherent patients. Cognitive Behavioral Therapy (CBT) is widely used, and it has been adapted to religious orientations, known as Religiously Integrated Cognitive Behavioral Therapy (RCBT). However, a significant issue remains that RCBT manuals maintain the same foundational assumptions and approaches while merely culturally adapting them to different faith groups (i.e., Judaism, Christianity, and Islam), despite theological differences in addressing psychological and spiritual issues (Haque et al., 2016).

Studies conducted on Muslim communities indicate a preference for Islamically integrated mental health treatment (Koç & Kafa, 2019; Mitha, 2020; Syed et al., 2020). Thus, traditional approaches rooted in Islamic thought, such as the theories and contributions of al-Ghazali, al-Razi, al-Kindi, and Ibn Sina, may be more suitable for Muslim patients seeking mental health care (Keshavarzi & Haque, 2013). In this context, theoretical models grounded in Islamic thought that value religious values and tradition are needed to expand psychotherapeutic care, address psychopathology, and develop unique interventions drawn from Islamic literature (Haque et. al., 2016).

In light of these concerns, this thesis is rooted in an inherently Islamic model of psychotherapy, Traditional Islamic Integrated Psychotherapy (TIIP), which combines the fundamental principles of the Islamic intellectual tradition with scientifically supported psychological principles (Keshavarzi et al., 2020).

The goal of the study is to develop and explore the utility of the TIIP Grief Protocol to help resolve unfinished business tension for Muslims who have experienced prolonged grief. Religious and spiritual practices play a crucial role in mental health treatment, with evidence demonstrating their effectiveness in addressing various psychological problems (Haque et al., 2016). A randomized, non-concurrent, multiple baseline design is planned for the proposed study of the TIIP grief protocol using five phases: (1) baseline phase, (2) empathic attunement phase, (3) Islamically integrated chair-work intervention phase, (4) cognitive consolidation and spiritually behavioral activation phase, and (5) follow-up phase. This study will demonstrate the utilization of the TIIP grief protocol in assisting bereaved Muslims facing numerous psychological, physiological, social, and economic risks to resolve the unfinished business on account of their prolonged grief. The importance of the proposed study stems from an Islamically integrated interventional method of providing closure to individuals experiencing prolonged grief that is otherwise not available in the literature.

1.2. Research Questions

i. Does the TIIP grief protocol produce a significant reduction in the degree of unfinished business compared to the baseline phase?

ii. Does achieving a moderate level of emotional arousal during the TIIP grief protocol predict a greater reduction in unfinished business among bereaved Muslims experiencing prolonged grief?

iii. Does participation in the TIIP grief protocol result in a decline in the prolonged grief symptoms among bereaved Muslims?

iv. Does the TIIP grief protocol facilitate a more adaptive cognitive orientation toward the deceased among bereaved Muslims?

CHAPTER II

LITERATURE REVIEW

2.1. Conceptualizing Grief

Although the loss of a loved one is an inevitable experience, it remains one of the most stressful life events (Holmes & Rahe, 1967). As Bowlby (1980) stated, seeking and maintaining close attachments, which are the innate human instinct, are essential for psychological well-being. Given that our attachment bonds with loved ones play a crucial role throughout life, their loss naturally evokes a robust emotional response.

Grief is conceptualized as a multifaceted emotional reaction identified by intense emotional suffering, yearning or longing for the deceased, a sense of shock or disbelief, and struggling with adapting to life after the loss (Papa et al., 2014). On the other hand, bereavement refers to the period of mourning and emotional difficulty that follows the death of a loved one (De Stefano et al., 2020).

Acute grief is regarded as a natural and adaptive emotional reaction to loss, and it commonly resolves over time without needing support from professionals (Bonanno et al., 2022; Kersting et al., 2011). The study indicated that, for most individuals, the intensity of grief decreases within the year following the loss (Bonanno & Kaltman, 2001; Hall, 2014). In contrast, it cannot be said that grief disappears entirely; instead, it becomes more integrated into the bereaved person's life and no longer disrupts daily functioning (Boelen & Lenferink, 2022; Djelantik et al., 2022; Hall, 2014). For that reason, acute grief is accepted as a normal, non-pathological reaction to loss (Djelantik et al., 2022; Hall, 2014).

On the other hand, for a significant minority, grief persists over time and becomes maladaptive, interfering with their ability to function and thrive. In those cases, the grief reactions may meet the criteria for a psychiatric diagnosis and require clinical

intervention (Papa et al., 2013; Prigerson et al., 2009; Prigerson, Boelen, et al., 2021; Shear et al., 2007).

Over the past few decades, studies have revealed that some bereaved individuals experience prolonged difficulties that exceed cultural, social, or religious norms of mourning (Djelantik et al., 2022; Hall, 2014; Maercker et al., 2013; Prigerson, Boelen, et al., 2021). The emotional manifestations of grief are generally characterized by sadness, shock, guilt, and numbness (De Stefano et al., 2020). These emotions may sometimes coexist with symptoms of psychological disorders such as anxiety, depression, or trauma-related reactions, including yearning, regret, anger, and emotional detachment.

Boelen and Smid (2017) estimate that approximately 10% of bereaved individuals are at risk of developing mental health disorders. A living systematic review on the bereavement due to the COVID-19 pandemic revealed that almost all of the studies (11 out of 12) showed the relationship between grief and mental health challenges (Reitsma et al., 2023). According to research results, individuals who have experienced the loss of a loved one have a higher risk of developing psychopathology in the first year after bereavement compared to non-grieving individuals, such as major depressive disorder (Chen et al., 2020), risk of suicide and self-harm (Prigerson, Kakarala, et al., 2021).

Grief is a multidimensional experience that extends beyond emotional responses to include physical, cognitive, social, and spiritual components (Bonanno & Kaltman, 2001; Lundorff et al., 2017). Previous studies have indicated that bereaved individuals are at increased risk for various psychological and physiological health issues —even after accounting for co-occurring anxiety and depression (Hall, 2014; Prigerson et al., 1995; Prigerson & Jacobs, 1997). The emotional distress caused by loss can trigger physical consequences (King et al., 2013), such as sleep disturbances (Szuhany, Young, et al., 2020), increased morbidity and mortality, and higher rates of disability and medication use (Prigerson et al., 2009). In addition, somatic manifestations such as changes in appetite, digestive problems, and breathing difficulties have been commonly reported (Bonanno & Kaltman, 2001).

From a cognitive position, intrusive thoughts, concentration problems, difficulty in decision making, derealization, and difficulty in accepting the death are common issues that bereaved people face (Bonanno & Kaltman, 2001). Cesur-Soysal and Durak-Batıgün (2020) reported that prolonged grief is closely associated with distorted beliefs and conceptualization of the self and the world after the loss. In addition, the Yale Bereavement Study stressed that reminders of the deceased related to cognitive avoidance strategies (Prigerson et al., 2021). Also, rumination about the loss reported as an essential cognitive process associated with impaired daily functioning and reduced quality of life (Eisma et al., 2015; Prigerson et al., 2009; Silverman et al., 2000) In this context, several psychotherapy protocols developed to support individuals following prevent include cognitive interventions aimed at strengthening coping mechanisms and reducing alternative thinking styles (e.g. Boelen, van den Hout, et al., 1006, Boelen & Prigerson, 2007; Reitsma et al., 2021, 2023; Rosner et al., 2011, 2018; Spuij et al., 2013; Wetherell, 2012).

Socially, grief often results in withdrawal and diminished participation in daily life. Bereaved individuals are generally more prone to spending time alone, which, in turn, can lead to problems with social roles (Maercker et al., 2013; Prigerson et al., 2009). Most bereaved people report decreased engagement in work, social, and recreational activities within the first year (Bonanno & Kaltman, 2001; Li et al., 2015). This social isolation can lower the quality of life and impair daily functioning (Boelen & Smid, 2017; Hall, 2014; Maercker et al., 2013). To parallel this situation, bereaved individuals generally face social difficulties. Recognizing this, Lenferink et al. (2023) developed an online psychotherapy program for bereaved individuals that includes two sessions specifically designed to encourage (re)engagement in social, recreational, and occupational activities.

Spiritually, bereavement can cause profound shifts -sometimes serving as a source of comfort, and other times of distress. Raduan et al. (2026) noted that grieving can cause profound emotional and cognitive changes that impact my spiritual beliefs, and that these changes vary widely across religious and cultural contexts. Spirituality/religiosity provides solace and a sense of connection to a greater power, thereby lessening the bereaved's sorrow (Čepulienė & Skruibis, 2022; Honoré et al., 2025). In addition, religious practices facilitate post-traumatic growth, allowing

individuals to find new meaning and purpose following the loss (Čepulienė & Skruibis, 2022; Honoré et al., 2025). Superdock et al. (2025) conducted interviews with parents who lost their children within the six years, revealing that bereaved parents reported their feelings or practices had changed after the loss. While some parents report growth in their belief system, others report questioning God (Superdock et al., 2025).

On the other hand, even if spirituality has frequently been linked to improved results after loss, spirituality can also be challenged by grief. It was reported that bereaved individuals sometimes question the meaning of life, fate, or divine justice (Bonanno & Kaltman, 2001).

Complicated spiritual grief (CSG) is conceptualized as experiencing difficulty in one's faith or spiritual/religious community (Burke et al., 2021; Burke & Neimeyer, 2012, 2014). This concept indicates that grief not only affects the bereaved's psychological well-being but also influences the shared rituals and coping mechanisms. Research has highlighted that spiritual engagement can moderate the level of grief and promote resilience (Hansen, 2014; Poursalehi et al., 2020). It reveals that grief affects various aspects of life. In the context of the multifaceted nature of grief, it can be said that the loss of a loved one affects the individual's body, mind, relationships, and worldview.

Bereaved individuals' reactions toward the grief varying according to several factor like the quality of the relationship between the deceased and the bereaved (Hall, 2014; Vedder, 2022), how the death was occurred (Cesur-Soysal & Durak-Batıgün, 2020), unpredictability of death (Kaltman & Bonanno, 2003), and the age and stage of life of the bereaved individual (Maccallum et al, 2015).

Although grief is a normal emotional response to loss, and most individuals gradually heal without formal intervention, a significant minority develop persistent and debilitating symptoms that call for deeper understanding and specialized care. Although the loss of a loved one is an inevitable experience for everyone, scholarly attention to the experiences of bereaved individuals has steadily increased over the past five decades (Li et al., 2015). Researchers have systematically examined the experiences of bereaved people to understand and make sense of the difference between 'healthy' and 'unhealthy' grief. Most empirical studies have focused on grief

among White, Western populations, with insufficient attention to cultural, gender, or religious variations (Beckett & Dykeman, 2017). While grief is now understood as a multifaceted experience shaped by emotional, cognitive, social, and spiritual processes, early theoretical frameworks laid the foundation for our current understanding of how individuals navigate the grieving process.

2.1.1. Foundational Theories of the Grieving Process

2.1.1.1. Psychoanalytic Theory–Sigmund Freud

From a chronological perspective, the development of grief theories within Western literature, Sigmund Freud (1917), stands out as the first notable theorist to conceptualize the mourning process. His classic book Morning and Melancholia establishes the foundation for understanding grief within the psychoanalytic tradition (Beckett & Dykeman, 2017). In the book, Freud distinguishes between two reactions to loss: a normative, adaptive process and melancholia, a pathological, self-destructive response. He argued that both reactions stem from the concept of "object loss," in which the individual is separated from a loved and libidinally cathected object (Freud, 1917).

Fraud (1917) conceptualized mourning as a neutral, albeit painful, process of withdrawing emotional energy (libido) from the lost object and eventually reinvesting it in a new attachment, known as cathexis. In the normal morning process, symptoms such as this interest in the external world, reduced energy, temporary denial, and end-stage directed anger are expected and transient. This reaction, while distressing, reflects the bereaved individual's attempt to adjust to a new reality without the deceased.

According to Freud (1917), the essential task of mourning involves engaging in "grief work" - the conscious and marked effort to relinquish bonds, expectations, and desires attached to the deceased. When grief work is completed, the individual becomes emotionally free to form new attachments. As he stated: "The ego becomes free and uninhibited again (Freud, 1917)."

Freud (1917) hypothesized that the nature of the relationship with the deceased shapes an individual's response to bereavement. The presence of ambivalent feelings -mixed emotions of love and hostility- toward the lost person can significantly hinder the mourning process. In such cases, rather than withdrawing libidinal energy and redirecting it outward, the individual internalizes the lost object and turns aggression inward, leading to melancholia. The internalization results in self-blame, guilt, and a decrease in self-esteem, mirroring the symptoms of clinical depression (Freud, 1917).

Freud (1917) stated that, when the bereaved individuals cannot detach from the lost object, they are experiencing melancholia. During the melancholia, the bereaved individual is not redirecting the libido into a new object; instead, they continue to yearn for the deceased (Freud, 1917). Because the deceased becomes a part of the ego, the bereaved individual channels the hostility and anger toward the deceased, which are felt initially toward the lost one. This intrapsychic process resulted in pathological grief accompanied by heightened self-criticism, lowered self-worth, and severe psychological pain (Freud, 1917).

To sum up, the psychoanalytic perspective on the mourning process involves three key stages to reach healthy grief resolution:

i. The release of the bereaved from psychological attachment to the deceased,

ii. Adjustment to life without the lost person,

iii. The formation of new relationships and investments (Hall, 2014)

Successful mourning, according to psychoanalytical theory, is marked by the capacity to love again, which involves transferring the deceased's energy to new life objects. In contrast, when the bereaved fails to disengage from the deceased due to unresolved ambivalence or unconscious conflict, the grief process may devolve into melancholia, representing what Freud termed pathological grief.

2.1.1.2. Attachment Theory–John Bowlby

John Bowlby (1961, 1963) was the first scholar to apply psychoanalytic terminology to describe grief within a normal population. In his seminal book *Attachment and Loss: Loss, Sadness and Depression,* Bowlby (1980) identified two disordered varieties of mourning: the prolonged absence of overt grieving, which you regarded as a disturbed variation, and chronic mourning, characterized by intense emotional distress and greater disruption than occurs in healthy mourning.

Much of Bowlby's understanding of grief was shaped by his clinical work with brave children (Bowlby, 1961). His model argues that both prior life experiences and genetic predispositions influence an individual's response to loss. Because attachments to loved ones are deeply rooted in human behavior, they are a permanent disruption that activates behavioral systems aimed at reestablishing proximity to the lost person.

Drawing on the clinical work of Lindemann (1944), Marris (1958), and Parkes (1971), Bowlby (1980) maintained that while individuals shared common emotional and behavioral responses, the subjective experience of grief is unique to each person. Bowlby (1980) proposed that grief typically progresses through four phases, which may occur in varying order and duration, and can overlap:

i. Numbness: A period lasting from several hours to a week, open, interspersed with episodes of acute distress or anger

ii. Yearning and searching: Persistent longing for the deceased, which may extend for months or even years.

iii. Disorganization and despair: Feelings of chaos, hopelessness, and difficulty in functioning.

iv. Reorganization: Gradual adaptation, involving the resumption of routines, engagement in social relationships, and the development of new life patterns (Bowlby, 1980).

Bowlby (1980) emphasized that these phases do not represent rigid stages but rather a general pattern through which many grieving individuals pass. The goal of the health improvement process is recovery and reorganization, allowing the breath to integrate the laws into their lives and re-engage with the daily functioning and social interaction (Rothaupt & Becker, 2007).

2.1.1.3. The Five Stage Model–Elisabeth Kübler-Ross

Since the publication of Mourning and Melancholia (Freud, 1917), there has been a significant gap in the lost literature, education, and practice for several decades. The contribution of Elizabeth Kübler-Ross was transformative for both practitioners and clients. Her work facilitated open discourse on the experience of dying and bereavement and provided the shared frameworks and terminology through which the process could be understood. Historically, Western culture has often regarded that as a fearful, complicated, and taboo subject (Beckett & Dykeman, 2017). The publication of On Death and Dying (1969) filled a significant gap in the field and quickly established Kübler-Ross as a leading authority. Her stage model of grief has since been applied widely in both academic and my contexts, extending beyond terminal illness to various forms of loss across individuals, cultures, and circumstances (Beckett & Dykeman, 2017).

Kübler-Ross' (1969) stages of grief theory was developed based on her personal research with a group of terminally ill patients as an attempt to look for commonalities in their experiences. It is important to note that her mother initially developed to describe the coping responses of patients who are facing their own mortality, rather than the bereavement experiences of survivors (Rothaupt & Becker, 2007). According to Kübler-Ross' model, grieving individuals progress through the stages in a linear sequence in response to loss, completing each before moving to the next. Kübler-Ross' (1969) five stages, adapted in part from Bowlby's (1980) grief theory, are as follows:

i. Denial: The patient's initial response to a terminal diagnosis is often one of shock, typically accompanied by a reaction, "No, this cannot be me." During this stage, denial is the primary coping mechanism because the illness is not accepted.

ii. Anger: When the patient realizes there is no mistake in the diagnosis, cannot continue to deny reality, and begins questioning the situation, like "Why me?" These questions lead to the experience of challenging emotions, such as anger, jealousy, and resentment toward others or toward God.

iii. Bargaining: The subsequent stage, though generally shorter, is considered more constructive than the preceding ones. Here, bargaining emerges as an attempt to negotiate a postponement of death, often in the form of appeals to God in exchange for past virtuous deeds or promises of future behavior.

iv. Depression: As the illness progresses and the patient becomes increasingly fatigued from medical interventions, surgeries, and treatments, previous emotional responses -whether steadiness, anger, or bargaining- diminish, giving way to profound sadness. This stage is marked by depression and an overwhelming sense of loss.

v. Acceptance: The final stage, provided the patient has sufficient time and supportive resources, is characterized by a shift away from anger or sorrow. Following the struggles of the earlier stages, the individual enters a state of acceptance of their mortality. Acceptance is not to be understood as a state of happiness, but rather as a calm resignation or emotional detachment in the face of the inevitable.

When this stage theory is applied to bereaved individuals, the goal of health agreement is understood as reaching an acceptance of the loss (Rothaupt & Becker, 2007). Kübler-Ross' model was among the first to suggest that discrete emotional sequences might underlie recovery after a difficult life event.

Nevertheless, stage theories offer a conceptual framework for complex grieving processes but fail to capture the complexity and diversity of physical, psychological, social, and spiritual needs experienced by bereaved individuals (Downe-Wamboldt & Tamlyn, 1997; Hall, 2014). Taken together, the contrast between the stage models and contemporary approaches is the movement from prescriptive, linear stages towards dynamic, meaning-centered, and ideographic models, which reflects an effort to

capture the complexity of bereavement more accurately and the growing evidence supporting a more flexible, individualized understanding of the grieving process (Boelen & Smid, 2017).

2.1.2. Contemporary Theories of the Grieving Process

2.1.2.1. The Dual Process Model–Stroebe and Schut

The dual process model of coping with bereavement, proposed by Stroebe and Shut (1999), offers a more flexible taxonomy for understanding how people adapt to the death of a loved one. The novelty of the dual process model lies in its allowance for fluctuation during bereavement, unlike the linear progression of the stage models. This model acts on the effects of individual differences on the bereavement process. The model assumes that people do not go through phases but instead fluctuate between two types of responses: loss-oriented tasks and restoration-oriented tasks (Strobe & Schut, 1999). Loss-oriented tasks involve confronting the pain of grief and dealing with the loss experience itself. This usually consists of yearning for the deceased, reflecting on life with them, and revisiting the circumstances of their death. Restoration-oriented tasks refer to secondary stressors and coping mechanisms that address practical challenges associated with adjusting to life without the deceased (Stroebe & Schut, 1999). Depending on internal and external demands, people perform these tasks at different times, using various methods, and to varying degrees (Beckett & Dykeman, 2017). The healthy bereavement period is called "oscillation," referring to the dynamic process of alternating between loss-oriented tasks and restoration-oriented coping (Stroebe & Schut, 1999).

2.1.2.2. Meaning Making–Robert A. Neimeyer

In contrast to models that prescribe detachment from the deceased, Neimeyer (2000) introduced a constructivist perspective emphasizing meaning-making in the wake of loss that focuses on the continuation of attachment. Drawing on evidence that randomized controlled trials of traditional grief counseling yielded limited efficacy, Neimeyer (2000) argued that the central task of grieving lies in reconstructing a sense of meaning of the loss and continuity of the relationship with the lost one. Qualitative

studies have further supported this view, highlighting that bereaved individuals often focus less on relinquishing the bond and more on integrating the loss into their evolving life narrative (Neimeyer, 2000). Regarding this finding, meaning-making, benefit-making, and identity change are key aspects of meaning reconstruction during the bereavement process (Gillies & Neimeyer, 2006).

In summary, modern models of grief emphasize the uniqueness of each bereaved individual's grief experience, whereas classical models accept the universality of the grieving process. Recently, modern models have been more widely accepted because they acknowledge the uniqueness of bereavement (Boelen & Smid, 2017). In contrast, classical models are recognized as failing to capture the validity of the grieving process (Hall, 2014). Even though empirical results revealed that letting go is not the healthiest way to grieve, classical stage models remain influential in shaping bereavement expectations in the general population (De Stefano et al., 2020; Maccallum et al., 2015). According to current knowledge, maintaining the bond adaptively is a healthy coping strategy during the grieving process (Hall, 2014).

2.1.3. Conceptualizations of Grief in Islamic Texts

The role of spiritual, religious, and cultural beliefs in shaping the grief experience and recovery was addressed by an increasing body of literature. In a recent systematic review, De Stefano et al. (2020) reported that spiritual, religious, and cultural beliefs and practices directly influence the grieving and recovery processes. Religion, religious rituals, and religious beliefs are among the key sources of solace and meaning-making during the grieving process (Aksoz-Efe et al., 2018). Religion can help people cope with death in three ways: by fostering a sense of community among the deceased's family, by framing death as a natural or positive occurrence, and by providing rituals that allow mourners to express their grief through symbolic gestures, prayers, or speeches (Ata, 2016). These practices aim to provide support to the bereaved, reduce anxiety, and provide a way for mourners to cope with their feelings of grief. While discussing death is arguably discouraged from a Western perspective, death is regarded as a natural part and process of life from an Islamic perspective (Davoudi, 2022). Death is viewed as an active process in resolving transitions from this world (dunya) to the next (akhira) (Hedayat, 2006). Muslim believes that all

people belong to Allah and ultimately return to Him at the end of their earthly existence (Qur'an, 2:28; trans. Hammad). Thus, the death of a loved one is to be both accepted and expected.

From an Islamic perspective, mourning stars and adaptive purpose go beyond what Western scholars commonly understand. Grief is not merely a psychological reaction but also a spiritual test and an opportunity for growth. Enduring sorrow, anxiety, and hardship with patience (sabr) is believed to elevate the believer's spiritual state and deepen their relationship with God. The Qur'an teaches: "He is the One Who creates death and life to test which of you is best in deeds. And he is the Almighty, All-forgiving (Qur'an, 67:2; trans. Hammad). Ibn Qayyim al-Jawziyya (2020) further emphasized that grief serves as a divine trial; if the believers remain steadfast and patient, God increases His love for them.

Islamic religious literature –including the Qur'an, the Hadith (sayings of the Prophet Muhammad, peace and blessing be upon him), and the Sîra (his biography)– places substantial attention on death and mourning. Believers are encouraged to show patience in the face of loss and discouraged from exaggerating this place of grief, such as wailing (Betriana & Kongsuwan, 2019). At the same time, the authentic expression of sadness, including weeping, is permitted and even modeled by the Prophet Muhammad (peace and blessings be upon him). For example, when his son Ibrahim passed away, he wept and declared: "The eyes shed tears and the heart is grieved, yes, we do not utter except what pleases our Lord. O Ibrahim! Indeed, we are grieved by your separation" (Sahih al-Bukhari, Hadith 1303). The Prophet exemplifies a role model for balancing emotional reactions with acknowledging the pain of grief and regulation under the influence of faith.

The ways of expressing grief and the rituals following the loss are directly affected by religious beliefs (Kristiansen & Sheikh, 2012). In Islamic practice, as a person nears death, they and those around them may recite the Shahada, a declaration of faith that states, "There is no God but Allah and Muhammad is the Messenger of Allah." At the moment of death or shortly thereafter, Muslims may say Takbir, which means "God is the greatest." After the person has passed, Muslims may recite the passage from the Qur'an that says, "We belong to God and truly to Him we shall return" (Quran, 2:156;

trans. Hammad). In the face of death, Muslims follow the rituals to remember the faith, which, in turn, helps them to find meaning-making for bereaved individuals. These practices help mourners anchor their grief in faith, supporting the process of meaning-making.

Islam emphasizes the communal responsibility of grief rituals. In this context, one of the rights of one Muslim over another is the right to attend the funeral prayer (salât al-janâzah) (Sahih al-Bukhari, Hadith 1240). The prayer for the deceased is usually held in a mosque, or masjid, an Islamic place of worship. During this prayer, the group present (the jamaat) asks for forgiveness for the deceased's sins. After the prayer, the deceased's family members may gather in small groups at the deceased's home or at the funeral home to recite the rosary (tasbeeh) and silently pray (du'â) for the deceased (Azhar, 2020).

Visiting the funeral house to offer condolences (ta'ziya) and show social support to the bereaved family is an essential part of the grieving process in Islamic practice. These visits typically last 7-40 days and involve discussing the deceased, sharing memories, and discussing the reasons for their death (Aksoz-Efe et al., 2018). Condolence visits often include religious practices such as praying and reciting the Qur'an, and the bereaved family is never left alone. Relatives and friends visit to provide physical support (such as cooking and cleaning) and psychological support (such as social support and condolences) to the bereaved family. Funeral prayers, visiting the funeral home, and reciting the Quran can provide both physical and psychological support to the grieving family (Aksoz-Efe et al., 2018). Through these practices, Islamic mourning rituals function simultaneously as expressions of solidarity, means of emotional support, and forms of spiritual coping that benefit both the bereaved and the deceased.

2.1.3.1. Grief in Early Islamic Thought

2.1.3.1.1. Al-Kindî (Alchindus)

Ya'qub ibn Ishaq al-Kindî, who lived in the 9th century, which coincided with the establishment of the House of Wisdom (Bait al-Hikma), where religious and rational

sciences were systematized in Islamic society (al-Kindî, 2015; trans. Kaya). He is recognized in history as the first Islamic philosopher to facilitate the transition from theology (kalam) to philosophy through his written works, employing his unique methodology and terminology (Hamarneh, 1965). Although al-Kindî produced a large amount of practical philosophical writing, much of it has unfortunately been lost. Only a few pieces remain, the longest and most significant of which is “On Dispelling Sorrow (Risala fi dafa’i al-ahzan)” housed at the Aya Sofya Library in Istanbul (Adamson, 2012; Hamarneh, 1965). This epistle primarily offers suggestions, proverbs, and stories that can help alleviate sorrow (huzn) and promote happiness (sa'adah) as a form of philosophical consolation (Stanford Encyclopedia of Philosophy, 2023). Upon examining the epistle, it becomes clear that al-Kindi's intention was not solely to pursue theoretical understanding of reality as a philosopher, but rather to provide a practical “way of living.” Thus, his work falls somewhere between the genres of health psychology or, as al-Kindi put it, “grief management" and “spiritual medicine” (Groff, 2004) with extensive psychological themes in the treatise (Hamarneh, 1965).

Al-Kindî begins by defining critical understanding, noting that the causes and the foundation are crucial for effective treatment. He states that sorrow is experienced as psychological pain that arises from the loss of a beloved object or the unfulfillment of something desired (al-Kindî, trans. Jayyusi-Lehn, 2002). He emphasizes the significance of the soul as the guiding force over the body, as it is through our souls, not our bodies, that our essence resides. Therefore, just as we endure physical pain and undergo unpleasant procedures to heal our bodies, you should also seek remedies for our souls. Al-Kindî conceptualizes sorrow as a pain or illness of the soul, and he proceeds to offer advice to readers on finding remedies for sorrow (al-Kindî, trans. Jayyusi-Lehn, 2002):

i. Analyzing various forms of grief, whether they arise from our own actions or those of others, allows us to make conscious choices. By avoiding activities that make him sad, he can gain better control over his feelings and act in accordance with his rational decisions.

ii. Reflecting on past experiences that once caused us grief, but have since been forgotten, as well as observing other experiences of grief and the subsequent comfort, provides us with tried and tested coping skills for managing our current sorrow. By recalling and drawing on these instances, we can heal our current sorrow by understanding and using coping techniques from previous experiences that alleviated our grief.

iii. Acknowledging struggles and sorrow as integral parts of daily life is crucial. To wish to avoid disasters is, in essence, to desire not existence, as calamities arise from the natural cycle of generation (kawn) and corruption (fasad). Al-Kindi understood generation as the process by which things come into existence, and corruption as the process by which things decay or disintegrate, leading to their eventual demise. According to this perspective, everything generated will ultimately be corrupted, except for psychological projections. Wishing not to lose a loved one is not possible; however, a person can handle the grief after the loss by making a unique psychological connection with the loved one.

iv. Instead of feeling envious of others' possessions, it is vital to cultivate gratitude towards Allah for the unique blessing bestowed upon us alone. These blessings are required through the innate goodness of our souls.

v. Recognizing death as an integral part of mortal existence. Death, often feared as the worst outcome, is not horribly bad in itself; it is the fear of death that makes us feel bad. Acknowledging death as a necessary component of life dispels ignorance regarding the nature of life and death, as it completes our natural cycle, and without it, humanity would not exist.

Al-Kindî argues that while loss is inevitable, grief is a choice that depends on how we manage the challenges of life. To cope with the pain of loss, he suggests that we can choose how we perceive the attachments we had with the deceased loved one. This means that recognizing the typologically evolved traits of long lines will continue even if we have lost their physical presence, which is vital for coping with grief (Hamarneh, 1965). According to Al-Kindî, joy and sorrow are significantly influenced by our

habits, and he urges readers to consciously cultivate habits that lead to genuine joy rather than remaining trapped in sorrow (Druart, 2000; Groff, 2004). By training ourselves, we can cultivate contentment and spiritual happiness, comforting ourselves in the process.

2.1.3.1.2. Abu Bakr Al-Razi (Rhazes)

Abu Bakr Muhammad ibn Zakariya Al-Razi is known as one of the most famous physicians of the Islamic world; however, he spent his formative years studying literature, mathematics, philosophy, and alchemy (Rāzī & Arberry, 1950). He lived in the 10th century, and his medical works were translated into Latin and remained in use in European medical schools for decades after his demise (Mohaghegh, 1967). According to Muslim philosophers, "moral philosophy" must be connected to practical philosophy, and they argued that physicians can only achieve excellence by combining both medical and philosophical knowledge. Al-Razi, a physician and philosopher, wrote "al-Tibb al-Ruhânî" (Spiritual Medicine), which is considered an essential contribution to the field of moral philosophy and early psychology, by providing a philosophy of the human psyche, its drives and a typology of character and virtues and providing a diagnostic method for assessing their presence and absence within an individual (Mohaghegh, 1967). Al-Razi's work consists of 20 chapters, one of which is devoted to coping with grief.

According to Al-Razi, when the mind brings to one's attention the absence of a cherished companion with an accompanying longing for them, it gives rise to the subsequent experience of sorrow (Rāzī & Arberry, 1950). Despite being a philosopher, Al-Razi doesn't offer a long or complex discussion of what grief is at the beginning of his epistle. Instead, the focus of his work is on the methods to repel grief. He divides his recommendations for coping with sorrow into two contexts: before and after the occurrence of sorrow.

I. Before sorrow occurs, the initial step in mitigating grief is a preventive approach. Al-Razi suggests preparing for loss by practicing imagining potential scenarios of loss before actually experiencing the loss of a loved one. The recommendation is rooted in the idea of training and gradually strengthening the psyche to be prepared for the day

calamity strikes. By adopting this approach, individuals can embrace grief as a natural part of life and learn to live with it, rather than resorting to unhealthy coping mechanisms such as trying to eliminate or avoid grief (Özcan, 2023).

II. After the occurrence of sorrow, the sequence step focuses on the recovery process. Al-Razi advises bereaved individuals to remind themselves that the misfortune they are experiencing will eventually pass and that they will eventually return to normalcy. This can be achieved by engaging distractions and occupying one's mind to facilitate the healing process. Al-Razi emphasizes the transient and mutable nature of all things in the world, subject to degeneration and loss, thereby highlighting their impermanence. By following this recommendation, bereaved individuals can move beyond the overwhelming emotions that often immobilize them during times of loss and be prepared for the future (Özcan, 2023).

2.1.3.1.3. Ibn Sînâ (Avicenna)

Abu Ali Ibn Sînâ, also known as Avicenna in the West, was a Muslim philosopher and physician who lived in the 11th century, a time when literature on science, theology, and philosophy flourished (Terzioğlu, 1999). His renowned works include "The Canon of Medicine" (al-Qanun fi't-Tibb), a medical encyclopedia, and "The Book of Healing" (al-Shifa), a philosophical and scientific encyclopedia, which were translated into Latin and served as textbooks in medieval medical schools until the 17th century (Scholar Community Encyclopedia, 2023). In addition to his contributions to medicine, Ibn Sînâ also made significant advancements in various scientific fields, including astronomy, alchemy, geography and geology, Islamic theology, logic, mathematics, physics, poetry, and psychology. In his book "A Treatise on the Cure for the Fear of Death" (Risala fi Def' al-Gam al-Mawt) (1959), he explores the fear of death as a common human phenomenon, noting that some individuals experience it more intensely than others. Drawing on Islamic teachings, he thoroughly examines fear of death and provides a step-by-step guide for managing mental distress caused by the fear of dying (Pajević et al., 2021). In the treatise, Ibn Sînâ (1959) categorizes those who fear death into five groups and offers specific advice for each group.

These categories are (Ibn Sînâ, 1959):

i. The person who is unaware of the reality of death.

ii. The person who is uncertain will happen to him after death.

iii. The person who believes that, in addition to pain associated with the condition that causes it, death itself causes essential suffering.

iv. The person who is concerned about being punished in the afterlife.

v. The person who laments the loss of their family, children, positions, and material comforts on account of death.

According to Ibn Sînâ, death is a natural part of life that facilitates the attainment of spiritual realization and the profession of faith. He describes the human being as a "creature that lives, thinks, and dies" (Ibn Sînâ, 1959). He asserts that there is a relationship between the fear of death and a deficiency in knowledge and awareness regarding it. As a scientist and practitioner, he alleviates this fear through enlightening them about the reality of death.

2.2. Grief as Psychopathology

Even though the majority of bereaved individuals gradually adapt to life without their loved one, a significant minority experience enduring reactions that impair daily functioning and warrant psychiatric diagnosis and treatment (Papa et al., 2013; Prigerson, Boelen, et al., 2021). Prolonged grief disorder (PGD) was formally recognized in March 2022 with the publication of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association, 2022). The DSM-5-TR defines PGD by persistent grief responses such as intense yearning or preoccupation with the deceased, alongside at least three symptoms, including identity disruption, disbelief about the death, avoidance of reminders, severe emotional pain, difficulty re-engaging with life, emotional numbness, feelings of meaninglessness, or profound loneliness. These symptoms must persist for at least 12 months in adults (six months in children). These

symptoms exceed social, cultural, or religious expectations of bereavement (American Psychiatric Association, 2022).

Epidemiological findings indicate that approximately 10% of bereaved adults meet criteria for PGD (Lundorff et al., 2017). This result highlights the significance of identifying and providing care to those bereaved individuals in greatest need to make the best use of economic and professional resources (Lundorff et al., 2017). International Classification of Diseases, 11th Revision (ICD-11, World Health Organization, 2019) defined the PGD as a persistent and pervasive longing for or preoccupation with the deceased and co-occurring with at least one grief response from the following: sadness, guilt, anger, denial, difficulty in accepting the death, and loss of meaning of life. These symptoms should persist for more than 6 months and clearly exceed cultural and religious expectations (World Health Organization, 2019).

Prevalence of PGD varies across diagnostic frameworks; estimates range from 4.7% to 6.8%, and the DSM-5-TR criteria yield lower rates than the ICD-11 criteria (Treml et al., 2024). Intrusive thoughts or images related to the deceased individual, longing for the deceased individual, and difficulty accepting the loss are the most common symptoms across both systems (Treml et al., 2024).

Notably, prevalence estimates vary across diagnostic frameworks, ranging from 4.7% to 6.8%, with DSM-5-TR criteria generally yielding lower rates than ICD-11 (Treml et al., 2024). The most common symptoms across both systems include intrusive thoughts/images related to the deceased person, longing for the deceased person, and difficulty accepting the loss (Treml et al., 2024). Despite these differences, both systems consistently highlight intrusive memories, intense longing, and difficulty accepting the loss as core features (Treml et al., 2024). Latent class analyses further suggest three subgroups of mourners: those with low symptoms (34.2%), predominantly PGD symptoms (38.7%), and high symptom levels across multiple domains (27%) (Treml et al., 2024).

PGD is frequently comorbid with other psychopathologies. According to research findings, those who have lost a loved one are more likely than those who have not to experience psychopathology in the first year following the loss. Research demonstrates

heightened risk for major depressive disorder (Chen et al., 2020), self-harm, and suicidality following bereavement (Prigerson, Kakarala, et al., 2021). In a large-scale study of terminally ill patients' caregivers, 12.1% reported depressive symptoms, and 7.6% reported complicated grief symptoms at six months post-loss, with 6% developing new-onset depression despite no pre-loss history (Nielsen et al., 2017). High rates of comorbidity have been reported with PTSD (48%), major depression (55%), and anxiety disorders (62%) (Simon et al., 2007). Similarly, Djelantik et al. (2022) found that 68% of individuals with PGD also met criteria for chronic depression and 15% for PTSD nearly 27 months after their loss.

PGD is associated with significant functional impairment, including reduced quality of life, physical health complaints, social and occupational impairment, and increased medical morbidity (Bonanno & Kaltman, 2001; Lundorff et al., 2017). Comorbid difficulties include substance use problems (Hall, 2014; Szuhany, Malgaroli, et al., 2020), sleep disruption (Boelen & Prigerson, 2007; Szuhany, Malgaroli, et al., 2020; Szuhany, Young, et al., 2020), and suicidal thoughts and behaviors (Prigerson et al., 2009, 2021; Shear et al., 2011). The disorder occurs in 9.8% of bereaved survivors and may be associated with increased risk of medical conditions such as cardiovascular disease, cancer, and immunological dysfunction (Khosravi & Kasaeiya, 2023).

Prevalence rates vary across cultures. The results of the first meta-analysis of studies from 1994–2016 estimated the global prevalence at around 10%, with Western studies reporting higher rates than Eastern ones (Lundorff et al., 2017). National studies have found prevalence estimates ranging from 3.4% in Germany (Treml et al., 2024) to nearly 10% in Spain (Peinado et al., 2024).

Several demographic and loss-related factors increase PGD risk, female gender (Boelen et al., 2015; Lenferink, Franzen, et al., 2023; Li et al., 2015; Szuhany, Malgaroli, et al., 2020), older ages (Boelen & Lenferink, 2022; Li et al., 2015; Lundorff et. al., 2017; Nielsen et al., 2017), low educational attainment (Boelen et al., 2015 & 2019; Boelen & Lenferink, 2022; Nielsen et al., 2017; Szuhany, Malgaroli, et al., 2020) kinship to the deceased (Boelen & Lenferink, 2022; Boelen & Smid, 2017; Cesur-Soysal & Durak-Batıgün, 2020; Lenferink, Franzen, et al., 2023), unnatural or violent causes of death (Boelen et al., 2019; Boelen & Lenferink, 2022; Lenferink,

Eisme, et al., 2023; Lenferink & Boelen, 2023), psychiatric history (Nielsen et al., 2017; Szuhany, Malgaroli, et al., 2020), and unexpected death (Boelen & Smid, 2017; Li et al., 2015; Szuhany, Malgaroli, et al., 2020). In this context, Rees and Lutkins (1967) found that the mortality rate among bereaved spouses was more than ten times higher than among non-bereaved peers.

PGD is distinguished from normal grief by its persistence, intensity, and functional impairment, which extend beyond sociocultural expectations (Papa et al., 2013; Prigerson et al., 2009; Prigerson, Boelen, et al., 2021; Shear et al., 2007). Acute grief is regarded as a standard, adaptive response that typically diminishes without intervention (Kersting et al., 2011), whereas PGD reflects a pathological trajectory in which symptoms remain protracted and disabling (Hall, 2014; Szuhany, Malgaroli, et al., 2020). Importantly, the pathology lies not in grief symptoms themselves but in their intensity and failure to resolve over time (Maciejewski et al., 2016).

To prevent pathologizing a normal response to loss, there was no distinct diagnosis until the DSM-5-TR (Papa et al., 2014; Prigerson, Boelen, et al., 2021), and the pathological grief reaction is also called prolonged, complicated, or traumatic grief in the research area (Papa et al., 2013). Before the DSM-5-TR, PGD was not separately recognized, and overlapping presentations were often diagnosed as major depressive disorder (MDD) or PTSD (Papa et al., 2014). Research now supports PGD as a distinct construct, differentiated from MDD and PTSD by its hallmark of separation distress—a unique cluster involving preoccupation with the deceased, yearning, intense loneliness, and difficulty moving forward (Dell'Osso et al., 2012; Papa et al., 2013). In addition, separation anxiety during childhood has been reported as a specific predictor for PGD (Prigerson et al., 2009)

Since the grief reaction could not be differentiated from other psychopathologies, such as MDD and PTSD, before the publication of the DSM-5-TR (American Psychiatric Association, 2022), bereaved individuals would typically receive different diagnoses. However, recent studies show that symptoms of PTSD, MDD, GAD, and prolonged grief reactions were separate factors in the sample of grieving people (Hall, 2014; Papa et al., 2014; Prigerson, Boelen, et al., 2021). Before the DSM-5-TR, PGD was not separately recognized, and overlapping presentations were often diagnosed as major

depressive disorder (MDD) or PTSD (Papa et al., 2014). Research now supports PGD as a distinct construct, differentiated from MDD and PTSD by its hallmark of separation distress—a unique cluster involving preoccupation with the deceased, yearning, intense loneliness, and difficulty moving forward (Dell'Osso et al., 2012; Papa et al., 2013).

Even though PGD represents overlapping symptoms with MDD and PTSD, loss-related cognitions are a key specifier for PGD, such as "If I fully realized what this death meant, I would lose my mind" (Prigerson et al., 2009). Thus, in the case of PGD diagnosis, PTSD, MDD, and acute grieving should be considered as differential diagnoses (Boelen, 2021).

Before acknowledging the PGD by DSM-5-TR, problematic grief responses were labeled as prolonged grief, complicated grief, or traumatic grief (Papa et al., 2023). Even though the terminology differed across the researchers, the interventions for problematic grief responses shared common principles. For example, Complicated Grief Therapy (CGT) proposed 16 structured sessions within three phases (Wetherell, 2012): (i) therapeutic alliance (sessions 1 - 3); imaginal revisiting of the deceased to address emotional and cognitive components (sessions 4 - 9); and consolidation of the progress and promoting adaptive coping skills (sessions 10 - 16). According to Abbasian and Sahragard's (2024) study, CGT is effective in reducing rumination, improving emotional regulation, and enhancing coping skills among individuals diagnosed with PGD.

Another structured therapy protocol is proposed by Beolen and Smid (2017), including a three-task framework: (i) exposing the loss-related memories and situations, (ii) challenging maladaptive cognitions and strengthening adaptive thinking, and (iii) behavioral activation to engage in meaningful activities. This protocol was applied by Reitsma and his colleagues (2021) to bereaved individuals due to COVID-19. Results highlight that the protocol is effective on the symptoms of PGD, post-traumatic stress, and depression, comparing the waitlist group and the changes were facilitated during the eight-week follow-up (Lenferink, Eisma, et al., 2023; Reitsma et al., 2023).

The diagnostic criteria for the PGD were tested using advanced statistical methods, including item response theory and combinatoric analysis, to identify optimal thresholds (Prigerson et al., 2009). Given these concerns, PGD was supported as a distinct diagnosis using validated questionnaires and evidence-based protocols (Prigerson et al., 2009).

On the other hand, significant limitations remain. The inconsistency between the DSM-5-TR and ICD-11 criteria leads to different prevalence rates and lower diagnostic agreement among clinicians (Treml et al., 2024). In addition, most studies were conducted in Western populations, raising questions about cross-cultural validity (Peinado et al., 2024).

The formal acknowledgement of PGD has consequences for mental health providers, including increased awareness of PGD as a distinct diagnosis, enabling appropriate screening and referral (Lundorff et al., 2017; Szuhany, Malgaroli, et al., 2020). Byrant (2013) stressed that millions of bereaved individuals are affected by this acknowledgement as a public health concern.

Bereaved individuals who suffer from pathological grief commonly report losing meaning in life (Hall, 2014; Holland & Neimeyer, 2010). Challenging in making sense of loss and reconstructing the meaning are distinguishing chronic grief from chronic depression (Hall, 2014). Struggling with integrating loss into the autobiographical memory and meaning-making system is a central psychological process in the development of PGD (Boelen et al., 2006). If the bereaved individual remains psychologically dependent on the lost one, then facing the difficulty of adapting to new life conditions without the deceased individual could be stuck, and grief reactions may become pathological.

Another hallmark of PGD is separation distress emerging from the struggle of the sustained adaptive emotional bond with the deceased (Field et al., 2005). Unfinished business is known as playing a role in this process, defined as unresolved conflicts, unexpressed emotions, or unmet needs with the other (Holland et al., 2020). The research revealed that nearly half of the bereaved individuals (43%) experience some degree of unfinished business tension (Klingspon et al., 2015). It was reported that

severe unfinished business tension is significantly associated with heightened psychological distress and severe grief symptoms (Hollan et al., 2020; Klingspon et al., 2014; Yamashita et al., 2017).

2.3. The Role of Unfinished Business in Prolonged Grief

Unfinished business is a core concept in Gestalt therapy and is frequently discussed in therapeutic contexts, especially concerning relationships and loss (Perls, 1972). It generally refers to unresolved emotionally laden interactions, experiences, or feelings that linger unexpressed or incomplete within an individual (Kellogg, 2015; O'Leary & Nieuwstraten; Perls, 1972). Such experience stems from the inhibition of emotions and unmet needs. When painful emotional experiences occur, individuals may block the expression of feelings and associated needs, preventing the typical sequence of arousal and expression from completing (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Tobin, 1971). This lack of completion leaves individuals feeling "stuck" psychologically and/or emotionally, unable to move forward (Greenberg & Malcolm, 2002; Kellogg, 2015; Perls, 1972). It creates a state of tension and can constrict the emergence of other experiences, as the "incomplete task" demands attention (Tobin, 1971).

Unfinished business tension in relationships often involves lingering negative feelings such as hurt, anger, resentment, or sadness toward a significant other (Greenberg & Malcolm, 2002; Syed, 2023). It includes previously unmet interpersonal needs (Goldman & Watson, 2011; Greenberg & Malcolm, 2002; Muntigl et al., 2017). This tension could arise when a relationship terminates through death, divorce, or separation, and the individual has not been able to adequately mourn or "let go" (Kellogg, 2004; Tobin, 1971). In bereavement, unfinished business includes incomplete or unresolved interpersonal concerns, resentments, slights, anger, unfulfilled dreams, wishes, and unspoken words directed toward the deceased (Klingspon et al., 2015; Yamashita et al., 2017). It can also involve unfulfilled wishes or missed opportunities of a positive nature, such as wishing to have said "I love you" more often, spend more time together, or share special memories (Holland et al., 2020; Klingspon et al., 2015).

Unfinished business has been associated with a range of psychological difficulties, including anxiety, depression, interpersonal problems, guilt, regret, and exceptionally prolonged grief reactions (Greenberg & Malcolm, 2002; Holland et al., 2020; Kellogg, 2015; Klingspon et al., 2015; Paivio & Greenberg, 1995; Tobin, 1971; Yamashita et al., 2017). Although its clinical significance, the empirical aspect specifically exploring unfinished business in the PGD remains surprisingly limited (Holland et al., 2020). Limited studies revealed that unfinished business is a critical risk factor for the development of PGD (Klingspon et al., 2015; Soysal, 2020; Yamashita et al., 2017). One example is Field and Horowitz's (1998) study, in which more unresolved conflict reported six months after the loss of a spouse significantly predicted depression and grief symptoms 18 months later. Similarly, persisting unresolved emotions were associated with severe grief symptoms (Holland et al., 2014).

Research indicates that PGD shares underlying mechanisms with other emotional disorders, particularly involving emotion-motivated avoidant coping (Spencer-Laitt et al. 2024). Such avoidance may specifically prevent resolution of unfinished business by blocking necessary emotional processing. In bereavement, avoidance coping often hinders adaptation by avoiding confrontation with the implications of the loss, obstructing the revision of attachment schemas, and delaying the construction of new life goals. Within this framework, unresolved aspects of the relationship – what may be termed unfinished business – can perpetuate grief symptoms by obstructing the adaptive reorganization of the continuing bond with the deceased (Rubin et al., 2020).

2.4. Chair-Work Dialogue

In the clinical literature, chair-work intervention is recognized as an effective and valuable therapeutic technique for addressing unresolved emotional tensions related to unfinished business (Field & Horowitz, 1998; Greenberg & Malcolm, 2002; Hagl et al., 2015; Muntigl et al., 2017; Paivio &Greenberg, 1995). Empty-chair dialogues are widely used to help clients express previously suppressed emotions and unmet needs, with the aims of achieving self-affirmation, developing a new understanding of the other, or holding them accountable (Greenberg et al., 1993; Greenberg & Malcolm, 2002; Syed, 2023; Watson et al., 2011).

Originating from Gestalt therapy, chair-work is often associated with “two-chair” and “empty-chair” dialogues (Kellogg, 2015; Kellogg et al., 2023; Perls et al., 1951). Chair-work dialogues help patients to resolve unfinished business via engaging in an imagined conversation with a significant other (Paivio & Greenberg, 1995). Over time, chair-work dialogues were integrated into various contemporary therapeutic approaches, including Emotion Focused Therapy (EFT), Schema Therapy (ST), and Cognitive Behavioral Therapy (CBT) (Kellogg, 2004).

Gestalt therapy emphasizes increasing awareness, resolving unfinished business, and integrating polarities within the self. Gestalt therapy primarily uses the concepts of intrinsic conflicts or “splits,” bringing the internal dialogue between opposing parts of the self into consciousness for reconciliation (Perls, 1972; Perls et al., 1951). The empty chair technique is used to achieve closure on unresolved feelings toward a significant other, facilitate the full expression of previously suppressed emotions, and acknowledge unmet needs (Perls et al., 1951).

From the ST perspective, chair-work is a central experiential method for treating patients, especially those with personality disorders (Kellogg, 2015; Rafaeli et al., 2015). ST conceptualizes patients as having different “schema modes” (e.g., vulnerable child, angry child, detached protector, punitive parent, healthy adult) and the primary goal is to strengthen the healthy adult mode and alter the overall configuration and balance of modes within the client (Josek et al., 2023; Rafaeli et al., 2015).

CBT has incorporated chair-work, recognizing that cognitive shifts are more likely to occur at higher levels of affect (Kellogg, 2004, 2015). Typically, one chair represents a dysfunctional thinking pattern or schema, and another represents a healthier, more adaptive alternative (Kellogg, 2004, 2015). The primary goal is to replace dysfunctional thinking with more adaptive thinking and restructure automatic thoughts and core beliefs (Kellogg, 2004). CBT chair-work typically adopts a directive rather than an exploratory stance, with clear desired outcomes from the outset, and relies on a Socratic and collaborative process between the therapist and client (Pugh, 2018).

EFT is a marker-guided approach, meaning specific interventions are applied in response to client behaviors that emerge in therapy, with a focus on facilitating emotional processing in the moment. Its core aim is to help clients develop emotional awareness, access primary adaptive emotions, regulate dysregulated emotions, and change maladaptive emotions (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). EFT employs chair-work as a marker-guided intervention, in which the therapist responds to clients' expressions of unresolved feelings toward significant others by initiating an empty-chair dialogue (Greenberg et al., 1993; Muntigl et al., 2017; Paivio & Greenberg, 1995).

Across various psychotherapeutic approaches, chair-work is generally guided by three overarching principles: multiplicity (the self is multifaceted), embodiment and personification (self-parts are made human-like form), and dialogue (self-parts or imagined others are encouraged to engage in conversation) (Kellogg, 2004; Pugh, 2018)

2.4.1. Resolving Unfinished Business via Empty Chair-Work Dialogue

According to Emotion-Focused Therapy (EFT), the resolution of unfinished business is achieved when individuals choose to adopt a self-affirming attitude and develop a deeper understanding, which may involve forgiving the imagined other or holding them accountable (Greenberg & Malcolm, 2002). Greenberg and his colleagues (Daldrup, 1988; Greenberg et al., 1993) have outlined the essential steps and markers for implementing chair-work within the framework of Emotionally Focused Therapy (EFT). A specified model of resolution involves six steps: (1) expressing blame, complaint, grief, and/or hurt; (2) role-playing the negative, frustrating other; (3) expressing intense primary emotions; (4) articulating previously unmet needs; (5) undergoing a shift in perception of the other; and finally, (6) achieving resolution (Greenberg & Malcolm, 2002). As chair-work is a marker-oriented experiential intervention, capturing the emotional marker (the first step), which symbolizes unfinished business, is the most crucial aspect of this phase (Greenberg & Foerster, 1996).

The effectiveness of chair-work dialogue stems from “doing” rather than “talking about” to achieve full awareness and integrate existing polarities by re-experiencing distressing emotions in the here-and-now (Kellogg, 2015). Research demonstrates that successful resolution is linked to emotional arousal, expression of unmet needs, perspective shifts, and self-affirmation, all of which predict better treatment outcomes (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995).

In bereavement interventions, empty chair dialogues are particularly valuable for addressing unfinished business with the deceased. The dialogues play an essential role in helping patients access their healthy primary adaptive emotions, needs, and behavioral inclinations that lead to emotional transformation (Muntigl et al., 2017). Guided imaginary dialogues enable the expression of unresolved feelings, the recognition of unmet needs, and the reconstruction of internal representations of the deceased, ultimately fostering adaptive restructuring of self and other (Field & Horowitz, 1998; Klingspon et al., 2015; Holland et al., 2020). The process is designed to allow re-experiencing and restructuring of earlier experiences (Greenberg et al., 1993).

At the beginning of the process, the therapist introduces the empty chair technique to externalize and explore unresolved emotional or relational conflicts. The client is invited to imagine the person they need to address (often a significant other or themselves) as being present in the empty chair. Patients are asked to guess the significant other in the empty chair and to voice unspoken thoughts, feelings, or grievances directly (Greenberg et al., 1993). And then the client switches chairs, alternating between their own perspective and that of the significant other, enhancing their ability to assert themselves and forgive (Muntigl et al., 2017). During the imaginal dialogue, the therapist plays a central role in guiding the client through the process of resolving unresolved feelings and achieving emotional relief channeled through an empty chair. (Greenberg et al., 1993).

Guided by the therapist, the patient becomes able to assert him- or herself, understand, forgive, and/or hold the significant other (deceased) accountable (Muntigl et al., 2017). Unlike conflict resolution in couple therapy, which involves mutual engagement, the empty chair task focuses on the individual's internal healing, independent of the other

person involved; thus, the empty chair dialogue is particularly effective for evaluating unresolved grief (Field & Horowitz, 1998).

The chief aim of unfinished business chair-work is to transform unresolved emotions by processing them to resolve emotional problems. The process of resolving unfinished business using the empty chair dialogue has been rigorously modeled and empirically verified (Greenberg et al., 1993; Paivio & Greenberg, 1995). Its key components and processes include (Greenberg & Malcolm, 2002):

i. Arousal and Expression of Primary Emotion: Patients are guided to express previously suppressed primary emotions such as hurt, anger, and sadness to the imagined significant other. This allows these feelings to run their course and be processed within the safe therapeutic environment. Emotional arousal is essential for therapeutic change.

ii. Mobilization and Expression of Unmet Needs: As emotions are expressed, clients identify and articulate unmet interpersonal needs previously. Where such needs cannot be met, the process involves recognizing their legitimacy and mourning their absence, thereby allowing the release of feelings of deprivation.

iii. Shifting Perspectives and Restructuring Schemas: Clients are encouraged to role-play the other to foster new perspectives. This fosters a shift from self-perceptions of weakness or victimization toward self-empowerment, while also allowing for more nuanced views of the other – whether through accountability, forgiveness, or understanding.

iv. Self-Affirmation and Letting Go: Resolution fosters a more self-affirming stance and enables clients to release unresolved emotions. “Saying goodbye” to relationships that have ended or changed is a vital way to resolve unfinished business.

Through chair-work, patients reconstruct their internal representations of others and restructure maladaptive self-other schemas. In EFT, imaginal dialogue emphasizes the

emotional impact of charged statements and interpersonal conflicts (Greenberg et al., 1993).

Empirical research provides strong support for the efficacy of chair-work in resolving unfinished business. Field and Horowitz (1998), for example, employed an empty chair monologue paradigm to assess unresolved grief and found that difficulties in symptoms. Similarly, Greenberg and Malcolm (2002) showed that clients who expressed unmet interpersonal needs during empty chair dialogues and experienced shifts in their view of the other reported greater improvements in symptom distress, interpersonal functioning, and resolution of target complaints.

Paivio and Greenberg (1995) further demonstrated that 81% of clients engaging in chair-work reported clinically meaningful improvement, compared to 35% in psychoeducation groups, with gains maintained at follow-ups up to 1 year. Moreover, the intensity of emotional arousal has been identified as a key factor: moderate emotional activation appears optimal for therapeutic change, while both sufficient and excessive arousal may hinder progress (Carryer & Greenberg, 2010; Lane et al., 2015). Emotional arousal is found to discriminate between clients who resolve their unfinished business and those who don't, indicating its importance in the change process (Greenberg & Malcolm, 2002).

The safety of the therapy environment has a significant effect on clients who avoid or suppress their emotions during the therapy process and seek to transform them. Thus, a strong therapeutic relationship based on client-centered principles, which are empathy, genuineness, and unconditional positive regard, is emphasized as foundational in EFT (Lee & Tratner, 2021; Shahar et al., 2012; Stiegler et al., 2018). Therapists attune to clients' moment-by-moment emotional experience, communicate empathic understanding, and facilitate collaboration on therapy tasks (Stiegler et al., 2018; Sutherland et al., 2014; Watson et al., 2011). While EFT therapists follow the clients' lead, they also use a more directive style to guide clients in specific progress part interventions (Muntigl et al., 2017). Therapists create a safe environment for clients to explore and confront painful, shameful, or anxiety-provoking experiences (Goldman & Watson, 2011; Sutherland et al., 2014). This involves balancing moment-

to-moment responsiveness with active stimulation to resolve unfinished business (Greenberg et al., 1993; Greenberg & Watson, 2005).

Unfinished business is a common focus of bereavement interventions, and the empty chair technique has been shown to provide individuals with a sense of resolution (Holland et al., 2020; Klingspon et al., 2015).

2.5. Theoretical Framework: Traditional Islamically Integrated Psychotherapy

Traditional Islamically Integrated Psychotherapy (TIIP) is an integrative model of mental health care grounded in the core principles of Islam, particularly Sunni Islamic teachings, and drawing on scientifically supported principles in psychology (Keshavarzi et al., 2020). The TIIP model, first proposed by Keshavarzi and Haque (2013), integrates Islamic theoretical principles with modern psychology to holistically address pathology, health, human behavior, and spirituality. With the collaboration of Fahad Khan, Bilal Ali, and other members of the research team at the Khalil Center, an outpatient research and mental health facility, the model has been further developed (Keshavarzi et al., 2020; Khan et al., 2023). It offers a structured approach to Islamic psychotherapy (Keshavarzi et al., 2020; Keshavarzi & Khan, 2018; Khan et al., 2023).

The TIIP's foundational framework is grounded in Islamic thought. TIIP derives its foundational assumptions from the generally agreed-upon positions of Sunni discursive theologians (Keshavarzi et al., 2020). Its ontological framework relies specifically on the conceptualization of the psyche or soul by classical Muslim scholars like Abû Hâmid al-Ghazâlî (d.1111 CE), Shihâb al-Dîn Abû Hafs al-Suhrawardî (d. 1234 CE), and Shah Walî Allah Dehlawî (d.1762 CE), adapted for psychological application (Keshavarzi et al., 2020). It also incorporates other Islamic traditions through a thematic review of psychologically relevant literature from scholastic theology (kalam), law (fiqh), philosophy (falsafah), medicine (tibb/hikmah), and spirituality (tasawwuf) (Keshavarzi et al., 2020; Khan et al., 2023). Furthermore, TIIP’s epistemological framework values scriptural, spiritual, empirical, and rational sources, ranking them hierarchically according to the strength of their evidence (Keshavarzi et al., 2020; Khan et al., 2023).

The theoretical principles of change in TIIP comprise four main goals for both the patient and the therapist to pursue in psychotherapy. The strategies used to bring about change align with the patient's goals and are implemented in a stagewise manner. These stages include inqiyâd (compliance), inkishâf (self-awareness), i'tidâl (equilibrium across all four elements of the psyche), and ittihâd (integrative unity of the psychic elements) (see Table 2.1).

Table 2.1. Process of Change in TIIP

	Stage 1	**Stage 2**	**Stage 3**	**Stage 4**
Principles of Change **(Patient)**	**Inqiyād**	**Inkishāf**	**Iʿtidāl**	**Ittiḥād**
	Compliance & motivation	Self- Awareness & uncovering	Emotional regulation, and emotional transformation	Integration of emotions into psyche through meaning making & spiritual behaviors
Mechanisms of Change **(Clinician)**	**Murābatah**	**Mukāshafah**	**Muʿālajah**	**Mu'wāsalah**
	Relationship formation	Introspective exploration	Interventions identify the primary factor(s)	Continuity & reflection on intervention

Reference: Keshavarzi et al., 2020

According to TIIP, the process of change begins by establishing the therapeutic alliance, termed "Murâbatah" (Keshavarzi & Ali, 2020). This is essential to achieving inqiyâd – compliance, motivation, and commitment on the part of the patient. Once the alliance is built, the second step, inkishâf (introspective self-awareness), focuses on exploring intrapsychic tensions, psychological distress, virtues/vices, and inner conflicts. This process is facilitated through therapist-guided interventions.

The third stage, *mu'âlajah*, involves transformation through interventions targeting the four elements of the psyche – 'aql, nafs, rûh, and ihsâs –to achieve psycho-spiritual

balance (i'tidâl). The therapist acts as practitioner, identifying and addressing the primary factor(s) contributing to the patient's difficulties.

The final stage, *mu'wâsalah* (consolidation), seeks to align the elements of the psyche so that no dissonance remains between them, culminating in inner integrative unity (*ittihâd*). This stage consolidates therapeutic gains, reviews strategies employed to achieve i'tidâl, and enables the patient to reassess acquired knowledge, fostering resilience against future distress.

The role of the TIIP practitioner is distinctive, bridging that of clinician and spiritual mentor (Sufî shaykh), yet differing from both. The therapist is regarded as a *Rafīq* (intimate friend, gentle companion, or partner) and operates collaboratively rather than hierarchically (Keshavarzi et al., 2020; Khan & Keshavarzi, 2023). TIIP therapists require strong foundational knowledge and skills, familiarity with Islamic spiritual interventions, and internal qualities such as sincerity and commitment to patient well-being. They are also expected to be engaged in their own journey of psycho-spiritual growth (Keshavarzi et al., 2020).

According to al-Ghazālī (Haque, 2004), the human soul consists of four interconnected aspects. This conceptualization is adopted in TIIP as follows: nafs (behavioral inclinations), ʿaql (cognition), rūḥ (spirit), and qalb (spiritual heart) (Keshavarzi & Haque, 2013). Later, iḥsās (emotion) was added to the model (Keshavarzi & Khan, 2018) (see Figure 2.1). Psychological interventions in TIIP are designed to improve the overall health of the psyche (psycho-spiritual equilibrium) by addressing specific elements (nafs, ʿaql, rūḥ, qalb, and iḥsās) identified through diagnostic assessment as the primary source of distress.

Key components of the psyche in TIIP include (Keshavarzi & Khan, 2018; Keshavarzi et al., 2020):

- ʾAql (Cognition): Intellect and its rational functions.
- Nafs (Behavioral Inclinations): Instincts and automatic behaviors, which can be disciplined to reach tranquility (muṭmaʾinnah).
- Rūḥ (Spirit): The most intricate aspect, associated with divine remembrance (*dhikr*) and spiritual connection.

- Qalb (Heart): The spiritual heart, the vessel for both health and pathology, and the locus of awareness of the Divine.
- Iḥsās (Emotions): Beyond biosocial processes, emotions carry spiritually inherent drives, serving as "alarm signals" that direct individuals toward ultimate needs.

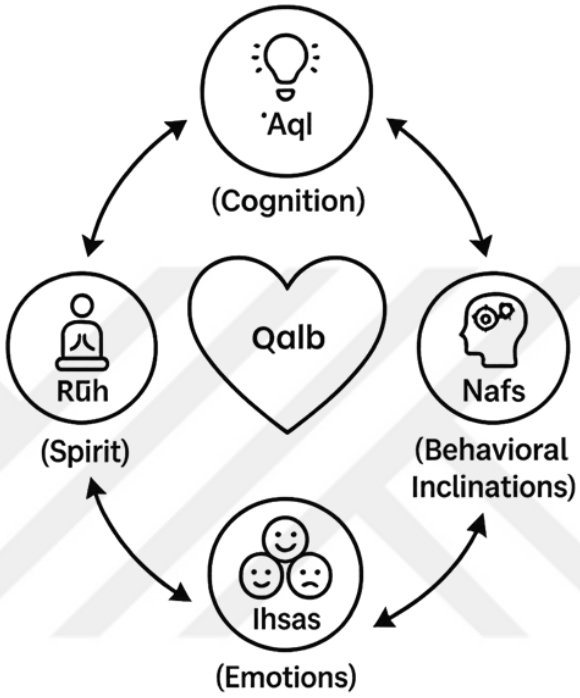


Figure 2.1. TIIP Model for Internal Human Psyche

Resource: Keshavarzi et al., 2020

The heart symbolizes a person's spiritual and metaphysical dimensions and serves as the container of both health and pathology. TIIP assumes a multiplex ontological view of the psyche as a multidimensional system where change in one domain affects the whole (Keshavarzi & Khan, 2018; Keshavarzi et al., 2020). The practitioner's role is to employ appropriate interventions to cultivate a "healthy heart" (*qalb*) (Keshavarzi & Haque, 2013). Health in TIIP is conceived holistically, encompassing virtuous behaviors, beliefs, and practices rather than merely the absence of pathology (Keshavarzi & Khan, 2018; Keshavarzi et al., 2020). It also recognizes spiritual illnesses often neglected by secular models, such as envy (*hasad*), which, if untreated,

may lead to anxiety, paranoia, anger, hatred, and bitterness of the heart (Khan & Keshavarzi, 2023).

TIIP employs a process-oriented diagnostic assessment to identify which elements of the psyche drive pathology and therefore require intervention. Once the primary element is determined, domain-specific interventions are applied to restore balance. For example, if the problem lies in cognition (‘aqlânî), signature cognitive interventions are used for restructuring, followed by attention to emotional, behavioral, and spiritual aspects. In the context of this study, the focus is on resolving unfinished business tension in bereaved individuals, referring to unresolved emotional tension between the bereaved and the deceased (Klingspon et al., 2015). Within the TIIP framework, the primary domain of focus is the ihsâsî (emotional) dimension, addressed through Islamically integrated chair-work. The ultimate aim is to alleviate dysfunction while cultivating psycho-spiritual resilience to prevent recurrence (Keshavarzi & Haque, 2013; Keshavarzi et al., 2020).

Preliminary evidence supports the efficacy of TIIP among the patients. A study at the Khalil Center with 107 patients showed reductions in clinical and functional distress, with outcomes attributed more to TIIP’s overarching philosophy than to specific interventions (Khan et al., 2023).

2.5.1. TIIP Protocol for Unfinished Business in Prolonged Grief

In the case of the loss of a loved one, intense emotional suffering is one of the key indicators of the PGD (Bonanno & Kaltman, 2001; De Stefano et al., 2020; Prigerson et al., 2021; Shear, 2010). The persistence of unresolved emotions is associated with greater severity of grief symptoms (Holland et al., 2014). According to TIIP, unfinished business is conceptualized as an emotionally charged (ihsâsî) problem. Emotions and their associated cognitions are understood to be shaped within sociocultural contexts. Therapeutically, the aim is to transform maladaptive emotions into adaptive ones, thereby promoting emotional transformation and cognitive reconsolidation (Keshavarzi & Keshavarzi, 2020).

In the context of grief, maladaptive expressions such as meaninglessness, numbness, hopelessness, and despondency need to be transformed into experiences of meaning, personal and spiritual growth, and a more profound sense of connectedness with both the deceased and God (Keshavarzi & Keshavarzi, 2020). In this framework, normal grief is obstructed by unresolved emotional issues – unfinished business – that must be addressed to allow meaning and connectedness to emerge.

During TIIP therapy sessions, marker-oriented interventions are employed based on the patient's specific emotional concerns (Keshavarzi et al., 2020). For unfinished business, the relevant marker is unresolved tension with "the other," which cues the therapist to use the empty chair protocol. Emotion theory holds that resolution of unfinished business occurs when individuals adopt a self-affirming stance and develop deeper understandings –this may involve forgiving the image and other or holding them accountable (Greenberg & Malcolm, 2002). Through emotional processing, patients can resolve conflicts, replace maladaptive emotions with adaptive ones, meet unmet emotional needs, and construct new meanings, ultimately leading to symptom reduction.

Reaching i'tidâl, –a state of balance and equilibrium among the components of psyche ('aql, rûh, nafs, ihsâs, and qalb)– is a central therapeutic goal of TIIP (Keshavarzi et al., 2020). The empty chair intervention is used to address unresolved tension and achieve closure, with a particular focus on restoring i'tidâl in the ihsâs (emotional) domain. By transforming maladaptive grief into adaptive expression, equilibrium is achieved, enabling the patient to experience healthy grief situated between two extremes: depressive despondency and avoidance. Patients are thus freed from oscillating between these extremes and can instead process emotions in ways that facilitate growth and reduce distress (see Figure 2.2). Through emotional activation and resolution, the TIIP chair-work intervention helps achieve psycho-spiritual equilibrium.

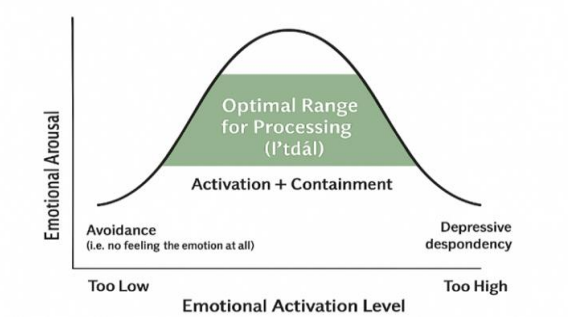


Figure 2.2. Optimal Range for Grief Processing in TIIP

2.5.2. TIIP Empty Chair-Work Intervention

The empty chair-wok dialogue is a marker-oriented approach used to address unresolved tension related to unfinished business. It allows patients to address unresolved emotional issues by engaging in an imagined dialogue with a significant other (Paivio & Greenberg, 1995). Originating in Gestalt therapy (Perls et al., 1972), this intervention is used across various psychotherapeutic approaches to facilitate psychological change and transformation (Kellogg, 2004). The TIIP empty chair-work intervention is an Islamic adaptation of the Emotional Focused Therapy (EFT) empty chair-work intervention, which was adopted as one of the TIIP's signature interventions (Keshavarzi et al., 2020). Its main departure from EFT lies in its conceptualization of the origin of emotions and in its aim: to cultivate patience and attain psychological and spiritual health (Qalb Salîm) (Keshavarzi et al., 2020).

In EFT, all emotions are believed to have an adaptive function, helping humans survive and thrive by addressing basic needs (Greenberg, 2010). TIIP theory acknowledged these adaptive survival instincts but extends beyond them, asserting that they also encompass spiritual needs (Keshavarzi & Khan, 2018). By incorporating metaphysical dimensions, TIIP highlights the spiritual and psychological facets that shape human emotions and motivations. Researching enrollment 107 patients demonstrated that the TIIP model, which integrates spiritual intentions with interventions, effectively reduces psychological distress and promotes positive mental health outcomes (Khan et al., 2023)

The TIIP grief protocol retains EFT's stages of emotional activation and processing but incorporates two additional elements: call me, the consolidation, and the formulation of the spiritual behavior plan. The central area of authentic business chair-work is the transformation of unresolved emotions into adaptive ones. Mechanism of change involves five stages: (i) emotional awareness, activation and expression, (ii) conscious awareness and emotional regulation (i.e. activation an optimal arousal of emotions), (iii) emotional reflection and evaluation of needs, (iv) transforming the core concern of emotional suffering, and (v) conscious cognitive consolidation (Keshavarzi & Keshavarzi, 2020).

In this regard, the TIIP framework posits that emotions trigger adaptive survival instincts, aligning with evolutionary psychology (Keshavarzi et al., 2020). However, TIIP goes beyond this by recognizing that these instinctual drives have multiple origins, not limited to biological needs in a social context (Keshavarzi et al., 2020). It acknowledges the inclusion of metaphysical energies related to the Divine and afterlife, addressing the inherent desire for meaning, belief in a higher power, and existential questions about the purpose of life that evolutionary psychology fails to adequately explain. Thus, the metaphysical aspect of human needs and drives is an essential component of TIIP's ontological structure of the human being (Keshavarzi et al., 2020). Ultimately, therapists assist in the discovery of adaptive reconsolidations of emotions, which challenge and transform patients' cognitive and emotional schemas (Keshavarzi & Keshavarzi, 2020).

2.5.3. Working With Emotions

Emotion schemas are an essential source of human experience and self-understanding (Greenberg, 2010). They consist of both innate responses and learn experiences, forming broader patterns of internal meaning. Although these schemes may not always be consciously accessible, they can be inferred through the experiences and behaviors they produce (Greenberg, 2004). Focused therapeutic attention is necessary to activate and process underlying emotional reactions, bringing them into conscious awareness and integrating them into corrective and meaningful experiences.

Emotion schemes play a key role in emotional transformation by shaping how individuals articulate, elaborate, and reinterpret their life stories (Warwar & Greenberg, 1999). The primary goal of emotion-focused work is to help patients change maladaptive states or unwanted self-experiences by activating and transforming emotions (Pos et al., 2017). Emotions are considered fundamental data of human experience, influencing meaning-making on narrative construction (Greenberg, 2004). Since emotions and cognitions are inextricably intertwined, transforming emotions naturally facilitates cognitive restructuring, ultimately alleviating psychological distress (Pascual-Lone & Greenberg, 2007).

Therapeutically, this involves a bottom-up approach, in which interventions target emotional activation and processing, leading to shifts in meaning-making and cognition. Emotional transformation occurs through empathic listening, evocative intimations, and reflective process (Greenberg, 2010). Four distinct classes of emotional responses are typically addressed: primary adaptive emotions, primary maladaptive emotions, secondary reactive emotions, and instrumental emotions (Greenberg, 2013). Understanding these categories enables both therapists and patients to more effectively identify, regulate, and transform emotions, thereby improving emotional regulation and mental health outcomes.

This approach employs a process-diagnostic method to determine which type of emotional response is active and in need of intervention. Research demonstrates that therapeutic success is closely tied to the degree of emotional arousal achieved during sessions (Lane et al., 2015). Emotional transformation process (see Figure 2.3) includes five steps (Greenberg, 2013; Greenberg & Goldman, 2019; Keshavarzi et al., 2020):

i. Emotional awareness, activation, and expression: the therapeutic process begins with developing emotional awareness, a foundational component emphasized in EFT (Greenberg, 2011). Patients are encouraged to recognize and label their emotions while attending to accompanying somatic cues such as tension or heaviness, consistent with theories that highlight the embodied nature of affect (Damasio, 1994). Do you think the activation expression of emotion that involves implicit, automatic responses can be brought into

conscious awareness, which is a necessary prerequisite for emotional processing and transformation? Clients who expressed unmet interpersonal needs shift their perspective on "the other," and affirm their sense of self, demonstrating significantly improved outcomes (Greenberg & Malcolm, 2002). Moreover, the presence of such resolution components is a stronger predictor of positive outcome than the therapeutic alliance alone (Greenberg & Malcolm, 2002).

ii. Conscious awareness and emotional regulation: Once emotions are accessed, they are brought into conscious awareness, allowing patients to begin regulating their intensity. The ability to regulate affective states is essential to adaptive functioning (Gross, 2014). Techniques such as deep breathing, mindfulness, grounding, and spiritually informed practices (e.g., dhikr, guided imagery) serve to downregulate hyperarousal and enhance emotional tolerance. Regulation does not suppress emotional experience; instead, it creates the psychological safety necessary for further therapeutic work.

iii. Reflection and evaluation of need: Emotions are viewed as carriers of implicit meaning, offline signaling unmet needs or unresolved concerns (Greenberg & Pascual-Lone, 2006). In this stage, patients are required to reflect on what their emotions revealed about underlying needs, thereby shifting from mere emotional experiencing to meaning-making. Such information provides insight into the functional significance of emotions and facilitates a more differentiated self-understanding.

iv. Transformation: The transformation, please, entails modifying maladaptive emotional responses by accessing primary adaptive emotions, such as grief, that lead to a cathartic release of anger, which supports assertive boundary-setting. According to emotion transformation theory (Greenberg, 2015), maladaptive emotions cannot be eliminated solely through cognitive strategies but must be replaced with new adaptive responses that are generated in therapeutic encounters. Techniques such as reframing, reprocessing, and the management dialogue are instrumental in fostering this shift.

v. Cognitive consolidation: The final stage involves integrating emotional change into the patient's cognitive schemas and meaning system. Emotional insights are consolidated through a reflective process, ensuring that new adaptive responses are internalized and generalized to daily life (Greenberg, 2011). This consolidation ensures that responses are not only internalized but also aligned with faith, thereby promoting long-term resilience and spiritual flourishing (Keshavarzi et al., 2020).

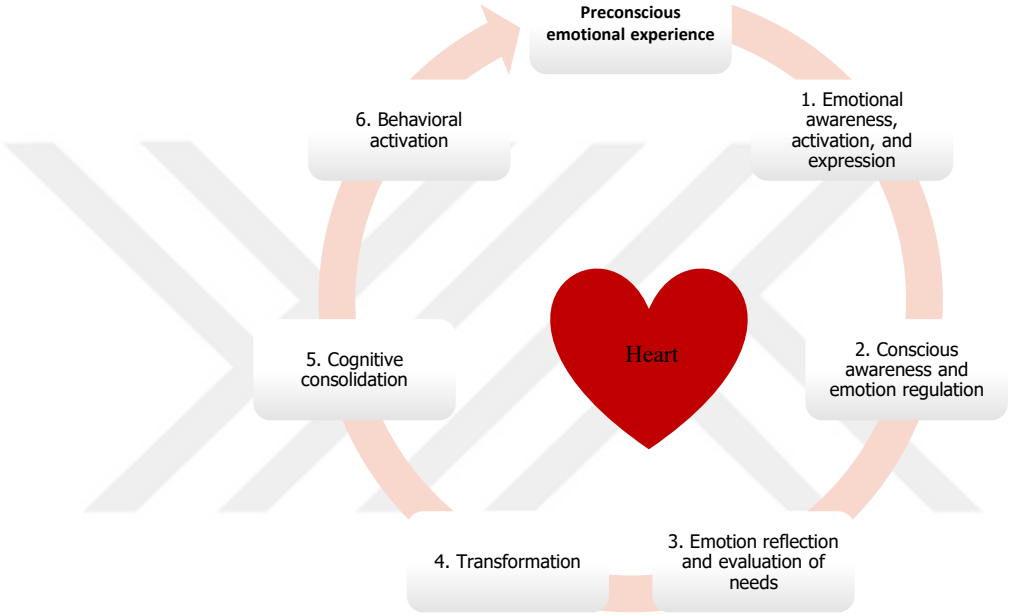


Figure 2.3. Emotional Transformation Process

A moderate level of emotional arousal –often described as the "optimal zone" – is most conducive to traffic change (Carryer & Greenberg, 2010). Evidence supports an inverted-U relationship between arousal and effectiveness: both too little and too much arousal can hinder progress (Lane et al., 2015).

2.6. Hypotheses of the Present Study

i. Participants will show a significant reduction in the degree of unfinished business following the TIIP grief protocol compared to the baseline phase.

ii. Moderate levels of emotional arousal during the TIIP grief protocol will be associated with a greater reduction in unfinished business among bereaved Muslims.

iii. Participation in the TIIP grief protocol will result in a significant reduction in prolonged grief symptoms among bereaved Muslims.

iv. The TIIP grief protocol will facilitate a more adaptive cognitive orientation toward the deceased among bereaved Muslims.

CHAPTER III

METHOD

3.1. Study Design

For the present study, ethical approval was obtained from the Ethics Committee of Ibn Haldun University (E-71395021-050.06.04-35013), and the trial was registered on ClinicalTrials.gov under the registration number NCT07193732.

This study implemented a practice-based methodology to demonstrate the multiplicity of clinical areas and evaluate the intervention in real-world contexts (Swisher, 2010). Therapists utilized the primary measurement at the end of each psychotherapy session to determine which particular intervention was effective in reducing unfinished business tension. This methodology helps to assess the mechanism of change in psychotherapy process research (Tompkins & Swift, 2015). Thereby, process-outcome research guides the identification of strategies to enhance the efficacy of psychotherapy (Tompkins & Swift, 2015).

A randomized, non-concurrent, multiple baseline experimental design across participants was utilized to evaluate the efficacy of the TIIP grief protocol for resolving unfinished-business tension in bereaved individuals. The multiple baseline design allows participants to operate as their own control group. This design tested the hypothesis that changes will be noticed only after introducing the intervention in a staggered manner to groups of participants. If symptoms are not expected to return to baseline after the intervention, as would be expected with a chair work intervention, this approach is appropriate (Barlow et al., 2009; Kazdin, 2020).

Participants were randomly assigned to different baseline periods: 2-, 4-, or 6-week. During the baseline, each participant completed the questionnaire weekly about the unfinished business. All participants attended the five phases: (1) baseline phase, (2)

empathy phase, (3) Islamically integrated chair-work intervention phase, (4) cognitive consolidation phase, and (5) one-month follow-up phase. During the baseline, treatment procedure, post-treatment, and one-month follow-up, participants answered a group of questions including primary and secondary outcome measures (see Table 3.1)

Table 3.1. Study Design

Phases	Intervention	Sessions / Duration
1	Baseline phase	2, 4 or 6 weeks
2	Empathic Attunement	1st & 2nd
3	TIIP chair-work intervention	3rd – 5th
4	Cognitive consolidation and spiritual behavioral plan	6th & 7th
5	Follow-up	1-month post-treatment

3.2. Participants

This study was designed to employ Islamically integrated chair-work intervention with bereaved Muslim patients experiencing unfinished business tension during the prolonged grief period. Participants were eligible for inclusion if they self-reported a strong religious affiliation with Islam, had experienced the death of a loved one between six months and five years before enrollment, and were experiencing unresolved tension related to the loss. This session was operationalized as a score of three or higher on the Unfinished Business in Bereavement Scale (UBBS). Exclusion criteria included individuals who were at imminent risk of suicide or self-harm, those currently dependent on alcohol or substances, and those with a history of or current diagnosis of psychotic or bipolar disorder. Participants who are currently engaged in any form of psychotherapy are also excluded. However, individuals who had been taking psychotropic medication for at least three months before the study were permitted to participate. In line with the logic of the multiple-baseline design,

participants served as their own controls by contributing data across different phases of the intervention.

In total, 90 individuals applied to the study via the online application system. Enrollment requests were first screened by trained research assistants. Of these applicants, 43 were excluded for failing to meet the inclusion criteria or for being otherwise deemed ineligible. The remaining 47 candidates were invited for further screening. Participants were informed about the research requirements and clinically interviewed by a research assistant via online meetings. Consent forms were obtained from eligible participants. Those who did not meet the criteria were referred to Ibn Haldun University Center for Psychotherapy Research (İPAM). 19 of them consented to participate in the study. Before the intervention commences, however, three participants withdrew due to scheduling difficulties or personal reasons. As a result, 16 individuals began therapy. During the intervention phase, seven participants reported that they would not continue psychotherapy. Ultimately, nine participants completed the full intervention and post-treatment evaluations. These nine individuals constitute the final sample analyzed in this study (see Figure 3.1).

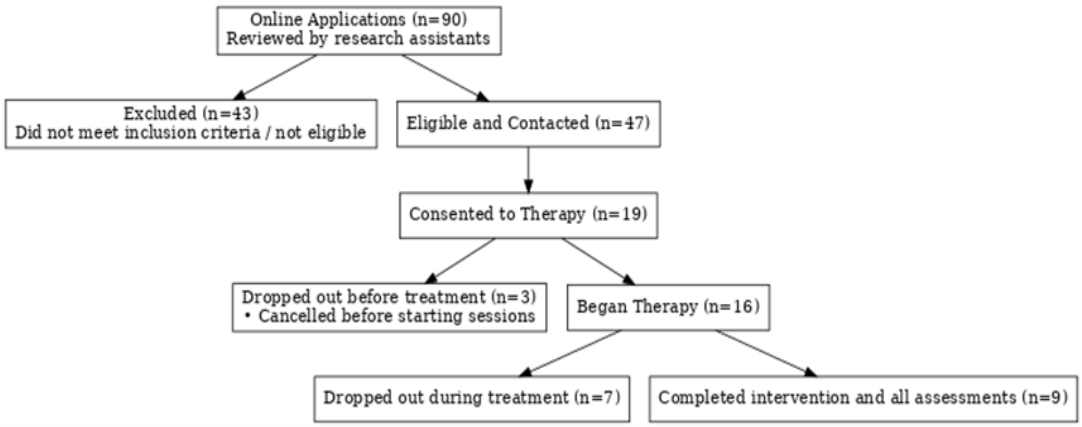


Figure 3.1. Participant Flow Diagram

3.3. Practitioners

For this study, three doctoral students in the Clinical Psychology program at Ibn Haldun University served as practitioners. The inclusion criteria for practitioners were: (a) being an intern psychologist at İPAM, (b) having actively seen clients under

supervision for at least three years, and (c) having completed at least one of the following doctoral-level courses at Ibn Haldun University: Introduction to Islamically Integrated Psychotherapy: Theory and Practice, Advanced Islamically Integrated Psychotherapy: Theory and Practice, or Process Experiential Psychotherapy.

To ensure treatment fidelity, the practitioners received structured training and supervision from Dr. Hooman Keshavarzi, the developer of Traditional Islamically Integrated Psychotherapy (TIIP) and the supervisor of this study. The detailed manual for the TIIP grief protocol was prepared by Dr. Hooman Keshavarzi, the principal investigator of the study. Before the study began, practitioners were trained using the structured manual. During the training, practitioners participate in theoretical and experiential workshops about the TIIP, working with emotions, and chair-work intervention. After the study began, practitioners took regular supervision from Dr. Keshavarzi to ensure adherence to the manual.

3.4. Procedure

3.4.1. The TIIP Grief Protocol

The Islamically integrated chair-work is based on the TIIP framework and an adaptation of the EFT chair-work techniques. Differentiating from EFT, TIIP chair-work intervention incorporates a cognitive consolidation phase and spiritual behavioral plan, which assists bereaved individuals in the process of finding meaning and planning adaptive spiritual behaviors after the loss of a loved one. This phase assists bereaved individuals in finding meaning after the loss of a loved one and in planning corresponding adaptive behaviors and spiritual exercises. Following emotional arousal, awareness, regulation, and reflection, conscious cognitive processes 'aql (intellect) are engaged as a consolidation of the previously conducted emotional work. Cognitive consolidation arises during discussions about needs and the interpretation of emotional expressions. This cognitive processing aids in consolidating adaptive growth and facilitates transformation, enabling patients to internalize the gains and insights acquired during treatment. The therapist’s position during the cognitive consolidation phase is more directive and co-constructive. Ultimately, therapists assist in discovering adaptive representations and meanings of

emotions that challenge and transform patients' maladaptive cognitive and emotional schemas (Keshavarzi & Keshavarzi, 2020).

Aligned with this cognitive transformation, spiritual behavioral activations involve planning to turn intentions into action and address uncovered needs, either during or after the session. This, in turn, consists of formulating a comprehensive and structured behavioral plan that integrates the newly acquired emotions and perspectives, thereby guiding actions and decisions in a more informed and emotionally attuned manner. Such a behavioral plan may include presenting the client with information from Islamic literature, like engaging in prayer, reciting the Qur'an regularly for the deceased, organizing group recitation, visiting the grave, paying off his/her debts, performing charitable deeds, and sharing acquired knowledge. The objective of these behaviors is to nurture the relationship with the deceased in a different realm.

By integrating insights from early Islamic thinkers with psychological counseling and incorporating cultural and religious elements, this intervention program aims to bridge a significant gap in existing literature. The study consists of five phases: (1) baseline phase, (2) empathy phase, (3) Islamically integrated chair-work intervention phase, (4) cognitive consolidation and spiritual behavioral plan phase, and (5) follow-up phase (see Table 3.2). The protocol was implemented weekly in a 50-minute, face-to-face individual format (see Appendix B).

Table 3.2. Summary Table of Psychotherapy Process

Phase	Sessions	Mechanisms of change (Practitioner)	Principals of change (Patient)	Intervention Component	Corresponding Grief Markers discussed by Islamic Scholars
1	1st 2nd	Murabatah (Relationship formation) Mukashafah (Introspective exploration)	Inqiyâd (Compliance & motivation) Inkishâf (Self-awareness & uncovering)	***Empathic Attunement*** Empathic following, scaffolding, and active listening techniques to activate and initial processing of feelings of grief	***Loss***: Losing a loved object causes intense pain (al-Kindi, trans. Jayyusi-Lehn, 2002). Processing natural pain to foster emotional awareness & understanding of the grief.
2		Mu'alajah (Chair-work intervention)	I'tidal (Emotional regulation, and emotional transformation)	***TIIP chair-work intervention*** Achieving i'tidâl through resolving maladaptive emotions and meeting unmet needs.	***Missed experiences:*** Future without the loved one (al-Kindi, trans. Jayyusi-Lehn, 2002). Discussion of unfulfilled dreams, feelings, resentments, regrets, wishes, and unresolved issues with the bereaved one that underly unfinished business and lead to a lack of closure ***Grief meditation:*** Imagining the scenarios of loss to prepare and emotionally process grief (Râzî, 1978) Addressing unfinished business and fostering emotional resolution & closure.
3		Muwasalah (Continuity & Reflection on intervention)	Ittihad (Integration of emotions into psyche through meaning making & spiritual behaviors)	***Cognitive consolidation and spiritual behavioral plan*** Transforming cognitive and emotional schemas to develop a unified, adaptive understanding of loss. Personalizing the purpose and divine wisdom	***Obscurity of death***: Struggling to form a healthy relationship with the concept of death (Ibn Sīnā, 1999). Meaning making through collaborative narrative reconstruction of death and spiritual behavioral practices —such as prayer, charity, or acts of remembrance—

3.4.1.1. Empathic Attunement Phase

The first step of the TIIP grief protocol focuses on creating a robust therapeutic alliance (murâbatah) with the patient to open a safe place for vulnerability and engagement (inqiyâd). In Islamic literature, there is an important place for strong relationships. For example, Imam al-Ghazâlî highlighted righteousness and companionship, and Imam al-Birgiviî stressed sincerity (sidq) as the characteristics of a healer, and Imam al-Bayjûri recommended careful consideration before implementation regarding their impact and potential for success (al-Bayjûri, 2002).

Building on al-Kindî's thoughts about the process of sorrow, the distinction of pain stemming from the loss of a loved one, and discomfort arising from unfulfilled desires with the deceased, these topics took their place in the TIIP grief protocol (al-Kindî, trans. Jayyusi-Lehn, 2002; Özcan, 2023). In the empathic attunement process, experiencing loss is central as bereavement is marked by severe sorrow (Papa et al., 2014). As a result, the first phase of the protocol prioritizes creating space to experience and process the natural pain of grief constructively.

Throughout the first phase, therapists focus on creating trust, reducing defensiveness, and preparing the patient to engage in therapy. Key strategies are active listening, empathic validation, and ongoing adherence to the sincerity and unconditioned positive regard principles. The role of the therapist is to lead patients toward self-awareness, to support the safe uncovering of grief-related pain, and to identify the unfinished business marker. Emotional attunement is facilitated by "listening with the third ear" (Reik, 1948), meaning that the therapists remain deeply moved by the patient's experience and respond in ways that strengthen therapeutic alliance (Galler & Greenberg, 2012).

In terms of interventions, the first session focused on four tasks: (i) validating the patient's emotions and experiences; (ii) collaboratively setting treatment goals centered on emotionally charged issues; (iii) motivating the patient to commit to the therapeutic process; and (iv) fostering hope for change. These goals were addressed by eliciting the patient's narrative of loss, attending carefully to verbal and nonverbal communication, and gently highlighting emotional struggles indicative of unfinished

business. In this way, murâbahat served as the therapeutic vehicle, enabling the patient to embrace vulnerability and prepare for the deeper emotional work in subsequent phases.

This stage also prepares patients for mukashafah (introspective discovery), a central element of TIIP. Through empathic presence and emotion-focused interventions, therapists help patients uncover hidden psychic material and clarify the origins of emotions, associated memories, and unmet needs. TIIP frames this within a model of "trilectical constructivism," which recognizes that emotions may stem not only from biological drives but also from the nafs, 'aql, and rûh (Keshavarzi et al., 2020). By evoking emotions across sessions, the therapist assists the patient in identifying these roots, thereby enhancing self-awareness.

The "pain compass" (Keshavarzi et al., 2020) serves as a guiding principle, directing therapists to follow narratives that activate grief-related pain. By engaging with these themes, patients are supported in achieving inkishâf (introspective self-awareness), a key step in preparing for transformation. In the second session, therapists deepened this process by encouraging greater emotional awareness, uncovering the natural pain of grief, and identifying unfinished business markers. Emphatic reflections, explorations, and conjectures were used to heighten emotional arousal, since meaningful change requires emotions to be directly felt, not merely discussed. As Imam al-Ghazâlî noted, blind spots are best uncovered through guided introspection within a psycho-spiritual relationship. This phase thus lays the foundation for effective transformation in the chair-work phase.

3.4.1.2. TIIP Chair-Work Phase

In TIIP, the process of psycho-spiritual healing is termed mu'âlajah. Its ultimate aim is the attainment of i'tidâl (equilibrium), achieved by restoring balance across the psyche's dimensions. A central concept integrated into this phase is al-Kindî's notion of "missed experiences," which refers to sorrow rooted in the absence of the deceased in the mourner's future. This encompasses unfulfilled wishes, unspoken feelings, and unrealized dreams. Research confirms that unresolved aspects of such experiences are strongly linked to maladaptive grief trajectories (Cesur-Sosyal & Durak-Batıgün,

2020). Thus, chair-work is used here to give voice to those unmet needs and to reduce the tension of unfinished business.

This method aligns with al-Râzî's reflection on grief, in which he recommended imaginatively rehearsing potential losses to confront and manage sorrow (Râzî & Arberry, 1950). In TIIP, imaginal dialogue with the deceased serves a similar purpose, helping patients face unresolved emotions in a guided, structured way. Through this intervention, maladaptive pain is transformed into adaptive sadness and emotional relief, allowing for growth and meaning-making.

This intervention was carried out during sessions three to five. Before enactment, the therapist introduced the rationale, emphasizing that chair-work offers patients the opportunity to express previously unvoiced thoughts and feelings. Patients were oriented to the process, often by being invited to face an empty chair representing the deceased and imagine their presence. If needed, therapists provided psychoeducation on the process and its therapeutic benefits.

This enactment itself followed a five-step resolution model (Greenberg & Malcolm, 2002):

i. Evoking emotions associated with the imagined presence of the deceased (e.g., hurt, anger, regret).

ii. Differentiating the bereaved individual's feelings from perceived negative qualities of the deceased.

iii. Intense emotional expression of unresolved feelings.

iv. Articulation of unmet needs, followed by the imagined validation of those needs from the deceased.

v. Transformation, often expressed as forgiveness, new understanding, or a shift in perception of the deceased.

Throughout the dialogue, patients alternated between the role of themselves and the role of the deceased (see Figure 3.2). In the bereaved role, the patient expressed thoughts and feelings openly, while the therapist supported awareness by reflecting on nonverbal cues, making emphatic conjectures, and guiding the patient to articulate unspoken wishes or needs. When assuming the role of the deceased, patients were encouraged to imagine the other's perspective. The therapist's role was to gently redirect patients to remain engaged with the imagined dialogue, ensuring that emotions were fully experienced rather than diverted back to the therapist.

At the end of the process, resolution was assessed through a sign of relief, closure, or a shift in perspective. The expected outcomes of this phase are reconciling unmet needs, reducing the intensity of unresolved emotions, and fostering a more adaptive internal representation of the self and the deceased. The aim was to reconstruct the internalized relationships that allow the patient to integrate loss in a manner consistent with both psychological health and religious meaning-making. In the end, TIIP chair-work intervention seeks not only emotional resolution but also the achievement of i'tidâl – a balanced state of the psyche – encompassing the 'aql, rûh, nafs, ihsâs, and qalb.

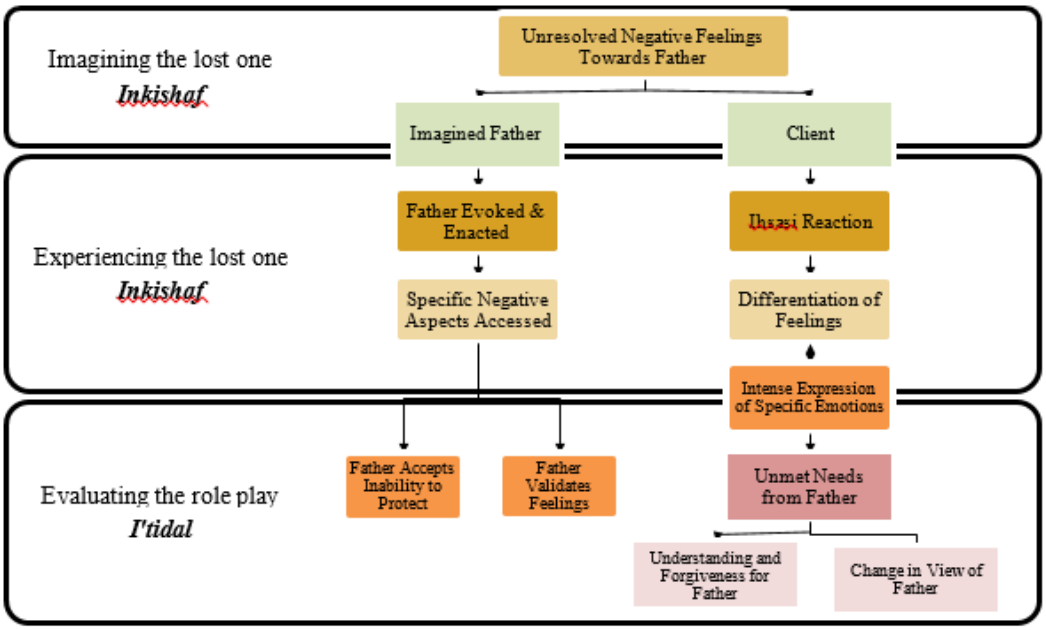


Figure 3.2. Example of the Components of the Resolution Model in the Third Phase

Resource: Keshavarzi & Keshavarzi, 2020

3.4.1.3. Cognitive Consolidation & Spiritual Behavioral Plan Phase

The last phase of the protocol, mu'wâsalah and ittihâd (consolidation and integration), is designed to align, eliminate dissonance, and internalize the therapeutic gains. This stage is based on Ibn Sînâ's thoughts, which highlight that death anxiety does not arise from death itself but from the fear of the unknown about the process. He suppressed that knowledge and understanding, which helped eliminate uncertainty and mitigate the sorrow (Pajević et al., 2021). From this perspective, the consolidation phase helps patients interpret the loss, address existential concerns, and achieve a more balanced psycho-spiritual outlook.

Following emotional activation and chair-work in earlier sessions, patients in this phase engage their 'aql (intellect) through reflection and cognitive restructuring. They are guided to interpret the insights gained during therapy, integrate adaptive narratives, and replace maladaptive emotional schemes with healthier ones. The therapeutic goals of this phase include finding significance in the loss experience, restructuring both cognitive and emotional frameworks, and developing behavioral strategies informed by newly discovered perspectives and emotions.

The therapist takes a co-constructive role, assisting patients in transforming emotional insight into sustained cognitive and spiritual growth (Keshavarzi & Keshavarzi, 2020). The therapist guides patients in consolidating their new emotional patterns, strengthening adaptive reactions, and creating alternative narratives consistent with their religious worldview.

The spiritual behavioral activation plans enhance the therapy gains by translating insights into practice. Patients are supported by personalized behavioral plans, such as performing charitable acts on behalf of the deceased, praying for them, caring for family members, or reflecting on the divine wisdom behind the loss. These actions sustain the deceased's religious connection by fostering resilience and meaning-making.

By the end of this phase, patients are encouraged to ask integrative questions such as "How can I honor the legacy of the deceased?" or "How can I derive meaning from

this death?" Through such exploration, they construct spiritually oriented behavioral activation plans that bring emotional insights into daily life. The ultimate goal is to achieve i'tidâl (equilibrium) and ittihâd (unity), understood not as spiritual perfection but as the reintegration of a psyche fragmented by grief. The therapist's role in this stage is to alleviate distress, foster resilience, and ensure that the various elements of the psyche are harmonized, enabling patients to pursue both psychological well-being and their spiritual potential.

3.4.2. Data Collection

Before the study commenced, during the recruitment stage, participants were informed about the research requirements and clinically interviewed by research assistants via online meetings. Consent forms were obtained from eligible participants; those who did not meet the criteria were referred to İPAM. Following the recruitment stage, eligible participants were randomly assigned to a 2-week, 4-week, or 6-week baseline phase. During the baseline period, participants completed the Unfinished Business in Bereavement Scale (UBBS) weekly to establish control data.

Before entering the subsequent treatment phase, participants completed a battery of self-report questionnaires. Throughout the following phases, participants received 50-minute individual sessions. At the end of each psychotherapy session, participants completed the UBBS to gather primary outcome measures. Additionally, the Client's Emotional Arousal Scale was used by practitioners to assess emotional arousal levels at the conclusion of each session.

After the last psychotherapy session, participants filled out a battery of self-report questionnaires, covering the degree of prolonged grief, severity of grief cognitions, depression, and anxiety. Follow-up data were collected via online surveys one month after the treatment. See Table 3.3 for detailed information regarding the timing of questionnaire administration.

Table 3.3. Administration Time of the Questionnaires

Name of the scale	Administration time
Socio-demographic form & Intake form	Recruitment phase
The Unfinished Business in Bereavement Scale (Holland, Klingspon, et al., 2020)	Baseline phase, 1st, 2nd, 3rd, 4th, 5th , 6th & 7th sessions, follow-up
Prolonged Grief Disorder-13 Scale (Prigerson et al., 2009)	1st & 7th sessions, follow-up
Grief Cognitions Questionnaire (Boelen & Lensvelt-Mulders, 2005)	1st & 7th sessions, follow-up
Patient Health Questionnaire-9 (Kroenke et. al., 2001)	1st & 7th sessions, follow-up
Generalized Anxiety Disorder-7 (Spitzer et. al., 2006)	1st & 7th sessions, follow-up
Client's Emotional Arousal Scale (Warwar & Greenberg, 1999)	1st, 2nd, 3rd, 4th, 5th , 6th & 7th sessions
Provider checklist	1st, 2nd, 3rd, 4th, 5th , 6th & 7th sessions

3.5. Fidelity

To ensure treatment fidelity, several procedures were implemented throughout the study. All therapists had completed coursework on Traditional Islamically Integrated Psychotherapy (TIIP) and emotion-focused interventions as part of their doctoral training. Prior to the commencement of the study, they participated in a structured training program led by the research supervisor, Dr. Hooman Keshavarzi, the developer of the TIIP framework. A detailed intervention manual, prepared specifically for this study, was used as the primary training and reference resource.

Training sessions included role-playing exercises based on the manual to provide hands-on practice with the intervention protocol before engaging with participants. In addition, therapists received ongoing individual supervision following each session and attended regular group supervision meetings. These supervisions focused on

reviewing session processes, addressing clinical challenges, and ensuring alignment with the TIIP model.

3.6. Measures

3.6.1. Intake Form and Socio-Demographic Questionnaire

The intake form and socio-demographic questionnaire developed for this study are meticulously structured to align with the study's inclusion and exclusion criteria. The intake form comprises questions pertaining to the duration since the loss, experiences of unresolved tensions, religious affiliation, risk of suicide or self-harm, and being over 18 years old. The socio-demographic questionnaire includes items related to gender, age, education level, occupational status, marital status, religious affiliation, relationship to the deceased, and psychiatric history. Furthermore, to enhance the reliability of inquiries regarding prayerfulness, the Practice subscale of the Muslim Practice and Belief Scale (Al-Marri et. al., 2008) has been incorporated into the sociodemographic questionnaire.

3.6.2. The Unfinished Business in Bereavement Scale–Brief (UBBS-Brief)

The Unfinished Business in Bereavement Scale - Brief (UBBS - Brief) is a self-report measurement tool developed by Holland et al. (2020). Utilizing a 5-point Likert scale (ranging from 1=Not at all distressed to 5=Extremely distressed), the UBBS-Brief comprises 8 items and includes two subscales: “unfulfilled wishes” and “unresolved conflict.” This abbreviated version demonstrates a robust correlation (ranging between 0.95 and 0.98) with the longer 28-item scale (Holland et al., 2020). Scoring between 1 and 5, with higher scores indicative of heightened distress, constitutes the total score. Cesur Soysal (2020) conducted the Turkish adaptation study of UBBS-Brief, reporting a Cronbach's alpha coefficient of 0.93 for the overall scale (with unresolved conflict α = 0.87 and unfulfilled wishes α = 0.89).

3.6.3. Prolonged Grief Disorder-13 Scale (PG-13)

The PG-13 (Prigerson et al., 2009) is a 13-item self-report instrument designed to assess symptoms of prolonged grief disorder. Eleven items are scored on a 5-point Likert scale (1=Not at all to 5 = Several times a day), while two items are yes/no questions assessing duration of grief (≥ 6 months) and functional impairment. The measure evaluates five diagnostic criteria: (A) event, (B) separation distress, (C) duration, (D) cognitive, emotional, and behavioral symptoms, and (E) impairment. Higher scores on the 11 Likert items indicate greater severity of prolonged grief. The Turkish validation study (Işıklı et al., 2020) reported strong internal consistency (α=.90).

3.6.4. Grief Cognitions Questionnaire (GCQ)

The GCQ (Boelen et al., 2003) measures maladaptive cognitions following bereavement. The original version includes 38 items rated on a 6-point Likert scale (0 = *Strongly disagree* to 5 = *Strongly agree*), organized into nine subscales. The Turkish adaption (Cesur & Durak-Batıgün, 2018) reduced the scale to 30 items across six subscales: negative cognitions about the future, self, world, emot,ons, and others, as well as *cherishing grief.* Scores range from 0 to 150, with higher values reflecting greater cognitive distress. Reliability analyses of the Turkish version demonstrated excellent internal consistency (α =.96 overall; subscales α=.77-91).

3.6.5. Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire - 9 (PHQ-9) was developed by Kroenke et al. (2001) to diagnose depression and measure the severity of depression and comprises nine items, a self-report assessment tool utilizing a 4-point Likert scale (ranging from 0 = not at all, 3 = nearly every day). Scores on the questionnaire range from 0 to 27, with a cut-off point of 10, higher scores indicating a severity of depressive symptoms. The Turkish adaptation of PHQ-9 conducted by Sari et al. (2016) revealed a robust internal consistency with a Cronbach's alpha coefficient of 0.84.

3.6.6. Generalized Anxiety Disorder-7 (GAD-7)

The Generalized Anxiety Disorder - 7 (GAD-7) was developed by Spitzer et al. (2006) to diagnose generalized anxiety and measure the severity of generalized anxiety and comprises seven items, a self-report assessment tool utilizing a four-point Likert scale (ranging from 0 = not at all, to 3 = nearly every day). Scores on the questionnaire range from 0 to 21, with higher scores indicating a more severe generalized anxiety symptom. In the Turkish adaptation conducted by Konkan et al. (2013), the identified cut-off score was 8, and the measurement exhibited a reliable internal consistency, as indicated by a Cronbach's alpha coefficient of 0.85.

3.6.7. The Client Emotional Arousal Scale III (CEAS-III)

The Client Emotional Arousal Scale - III (CEAS-III), devised by Warwar and Greenberg (1999), is an observer-rated measure designed to assess the depth and intensity of clients' emotional expressions. This scale examines emotional arousal by analyzing both vocal and bodily cues, utilizing a 7-point scale to rate the intensity of expressed emotions. CEAS-III focuses on primary emotions, including anger, fear, joy, love, sadness, and surprise, and differentiates emotional levels, ranging from lower levels (1-3) indicating limited emotional arousal to higher levels (4-7) representing increased intensity. Level 4 signifies moderate arousal with noticeable disruptions in speech patterns due to emotional overflow, while level 7 indicates an extremely intense and uncontrollable emotional state resulting in a significant disruption of usual speech patterns. Assessments entail identifying the primary emotion expressed and rating both the modal (most frequent) and peak (highest) intensities of the expressed emotional arousal. Notably, CEAS-III is an observer-rated ordinal measure used to gauge clients' expressed emotional arousal levels across various primary emotions. According to previous studies, interrater reliability of the CEAS-III ranged from .75 to .81 (Carry & Greenberg, 2010).

Table 3.4. Summary of Measures Used in the Study

Measure	Purpose	Items/Scale	Scoring	Reliability
UBBS–Brief (Holland et al., 2020)	Measures unresolved relational issues (unfulfilled wishes, unresolved conflict)	8 items; 5-point Likert (1–5); 2 subscales	Higher scores = greater unfinished business distress	α = .93 overall; subscales .87–.89 (Turkish)
PG-13 (Prigerson et al., 2009)	Assesses prolonged grief symptoms and diagnostic criteria	13 items; 11 Likert (1–5), 2 yes/no	Higher scores = greater severity of prolonged grief	α = .90 (Turkish)
GCQ (Boelen et al., 2003)	Evaluates maladaptive cognitions following bereavement	30 items (Turkish version); 6-point Likert (0–5)	0–150; higher = greater maladaptive cognitions	α = .96 overall; subscales .77–.91 (Turkish)
PHQ-9 (Kroenke et al., 2001)	Assesses depressive symptoms and severity	9 items; 4-point Likert (0–3)	0–27; cut-off ≥10 for clinical depression	α = .84 (Turkish)
GAD-7 (Spitzer et al., 2006)	Assesses generalized anxiety symptoms and severity	7 items; 4-point Likert (0–3)	0–21; cut-off ≥8 for clinical anxiety	α = .85 (Turkish)
CEAS-III (Warwar & Greenberg, 1999)	Observer-rated emotional arousal during therapy	Observer-rated; 7-point scale for vocal and bodily cues	1–3 = low, 4 = moderate, 5–7 = high arousal	Interrater reliability = .75–.81

3.6. Data Analysis

All analyses were conducted using R Studio (version 4.5.1; R Core Team, 2025). The analytic strategy combined both single-case design standards and statistical procedures to evaluate the impact of the TIIP grief protocol on the grief-related outcomes.

3.7.1. Visual Inspection

In accordance with established guidelines for single-case experimental designs (Barlow et al., 2009; Kazdin, 2011), initial analyses involved visual inspection of graphed data across baseline, intervention, and follow-up phases. This method allowed for the evaluation of within- and between-subject change patterns, with attention to level, trend, variability, and overlap between phases. Visual inspection provided preliminary evidence of treatment effects and guided the interpretation of subsequent statistical results.

3.7.2. Nonparametric Tests

To complement visual analyses, the Wilcoxon Signed Ranks Test was used to compare pre-treatment and post-treatment scores, as well as baseline and follow-up scores, on all outcome measures (prolonged grief, grief cognitions, depression, anxiety, and unfinished business). Given the small sample size and non-normal distribution of scores, the Wilcoxon test was selected as a robust nonparametric alternative to paired-sample t-tests.

3.7.3. Effect Size Estimation

Single-case effect sizes were calculated using Tau-U, a recommended nonparametric index for multiple baseline designs (Parker et al., 2011). Tau-U accounts for both non-overlap between phases and baseline trends, providing a robust estimate of treatment effect size. Analyses were performed for each participant and across participants, with 90% confidence intervals reported to reflect the strength and precision of the effects.

3.7.4. Clinical Significance

To determine whether observed changes were not only statistically significant but also clinically meaningful, the Reliable Change Index (RCI) and Jacobson-Truax (JT) method (Jacobson & Truax, 1991) were applied to each outcome measure. The RCI was calculated using published reliability coefficients and standard deviations from validation studies of each scale. Changes were then categorized as “reliable improvement,” no reliable change,” or “reliable deterioration.” In addition, JT criteria were used to assess whether post-treatment scores crossed established cut-off thresholds between the clinical and non-clinical ranges.

CHAPTER IV

RESULTS

4.1. Participant's Characteristics

A total of nine participants took part in the study. All nine participants met the criteria for clinically significant prolonged grief. Each scored above the established cut-off point of 30 on the PG-13 scale and endorsed Item 3, which assesses intense yearning or longing for the deceased (Criterion A in DSM-5-TR for Prolonged Grief Disorder). These findings confirm that the entire sample met the diagnostic threshold for Prolonged Grief Disorder at study entry (see Table 4.1.1).

Participants also reported experiencing unresolved relational tension connected to the deceased. All endorsed the screening statement "*People who have lost a significant person in their lives may sometimes feel that something has been left unsaid, unfinished, or unresolved with the deceased*," and their mean scores on the Unfinished Business in Bereavement Scale (UBBS) exceeded the threshold value (> 3). This indicates that the sample not only displayed elevated grief symptoms but also struggled with significant unfinished business tension, aligning with the therapeutic focus of the study.

Consistent with the study's eligibility requirements, participants represented bereaved individuals with a strong religious affiliation who had experienced a significant loss within the past 6 months to 5 years. None were undergoing psychotherapy at the time of participation, nor did they present with acute risk of suicide, psychosis, or substance dependence. None of them uses psychotropic medication.

Table 4.1. Sociodemographic and Clinical Characteristics of Participants

Participant	Age	Time Since Loss	Current Psychotherapy	Gender	Education Level	Employment Status	Marital Status	Relationship to Deceased	Cause of Death	Psychological Help After Loss	Psychiatric Help After Loss	Psychiatric Diagnosis in Family	Previous Psychiatric Diagnosis	UBBS Score	PG-13 Score
P1	23	5 years	No	Female	University graduate	Unemployed, job seeking	Single	Father	Cancer	Yes	No	No	No	3.625	51
P2	28	1 year	No	Female	University graduate	Employed	Married	Mother	Cancer	No	No	No	No	4.375	51
P3	26	6 months	No	Female	University graduate	Unemployed, job seeking	Single	Grandparent	Cancer	No	No	Yes	No	3.125	34
P4	25	3 years	No	Female	University graduate	Unemployed, job seeking	Single	Father	Covid-19	Yes	No	No	No	3.5	46
P5	33	4 years	No	Female	Associate degree	Housewife	Married	Mother	Covid-19	No	No	Yes	No	4.375	44
P6	32	3 years	No	Female	Associate degree	Employed	Widowed	Spouse	Covid-19	Yes	No	No	No	3.125	49

Table 4.1. (cont.)

P7	31	6 months	No	Female	Associate degree	Unemployed, not seeking	Single	Father	Herat attack	No	No	Yes	No	4.375	39
P8	29	3 years	No	Female	High school graduate	Housewife	Married	Father	Covid-19	No	No	No	No	3.75	49
P9	65	6 months	No	Female	Primary/secondary school	Housewife	Married	Sibling	Cancer	No	No	No	Yes	4.25	35

Note. UBBS = Unfinished Business in Bereavement Scale; PGD = Prolonged Grief Disorder-13 Scale (PG-13). Higher UBBS scores reflect greater unfinished business beliefs (range: 1–5). Higher PGD scores reflect greater grief severity (range: 11–66).

The study included nine bereaved women (M age = 32.44, SD = 12.65, range 23–65). Time since loss varied between 6 months and 5 years. The majority were married (44.4%) or single (33.3%), most had either a university (44.4%) or associate degree (33.3%), and only a minority of participants were employed (22.2%, n = 2). The most common losses were of a father (44.4%) or mother (22.2%), with additional losses of a spouse, sibling, and grandparent.

Regarding psychological and psychiatric history, most participants had not previously received structured psychotherapy for grief (n = 6, 66.7%). Two participants (22.2%) had sought psychological support in the past, while one reported a previous psychiatric diagnosis. None of the participants had received psychiatric treatment following their loss. A third of the sample (33.3%) reported a family history of psychiatric diagnosis. UBBS scores (M = 3.83, SD = 0.53) and PG-13 scores (M = 44.22, SD = 6.69) indicated clinically relevant unfinished tension and prolonged grief disorder symptoms. Table 4.1 summarizes the demographic and baseline characteristics of the participants.

Table 4.2. Participants Characteristics–General View

Variable	**n**	**%**
Gender		
Female	9	100
Age (years)	M = 32.44, SD = 12.65, Range = 23–65	
Time since loss		
6 months	3	33.3
1–3 years	3	33.3
4–5 years	3	33.3
Current psychotherapy	0	0
Education level		
Primary/secondary school	1	11.1
High school graduate	1	11.1
Associate degree	3	33.3
University graduate	4	44.4

Table 4.2. (cont.)

Employment status		
Employed	2	22.2
Unemployed (job seeking)	3	33.3
Unemployed (not seeking)	1	11.1
Housewife	3	33.3
Marital status		
Single	3	33.3
Married	4	44.4
Widowed	1	11.1
Relationship to deceased		
Father	4	44.4
Mother	2	22.2
Spouse	1	11.1
Sibling	1	11.1
Grandparent	1	11.1
Psychological help after loss	Yes: 2 (22.2)	No: 7 (77.8)
Psychiatric help after loss	Yes: 0	No: 9 (100)
Family psychiatric history	Yes: 3 (33.3)	No: 6 (66.7)
Previous psychiatric diagnosis	Yes: 1 (11.1)	No: 8 (88.9)
UBBS score	M = 3.83, SD = 0.53, Range = 3.13–4.38	
PGD score	M = 44.22, SD = 6.69, Range = 34 – 51	

4.2. Baseline Data

During the study, participants were randomly allocated to 2-, 4-, and 6-week baseline phases. At the first data collection point, baseline scores were above the established cut-off, ranging from 3 to 4.625 (M = 3.67, SD = 0.68). Table 4.3 reports the participants' UBBS scores during the baseline phase.

Table 4.3. Baseline Scores for Participants

Participant ID	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Mean
P1	3.375	3.5					3.44
P2	4.25	4.375					4.31
P3	2.875	2.5					2.69
P4	3.375	2.875	2.875	3.5			3.16
P5	4.625	4.375	4.625	4.625			4.56
P6	3.125	2.875	2.375	2.75			2.78
P7	4.625	4.375	4.125	4.625			4.44
P8	3.75	4	4	4.125	4	3.875	3.96
P9	3	2.5	1.875	2.875	2.125	2.125	2.42

Figure 4.1. represents each participant's baseline scores. All participants demonstrated stable scores during the baseline phase, except for P9, whose trajectory showed notable fluctuations.

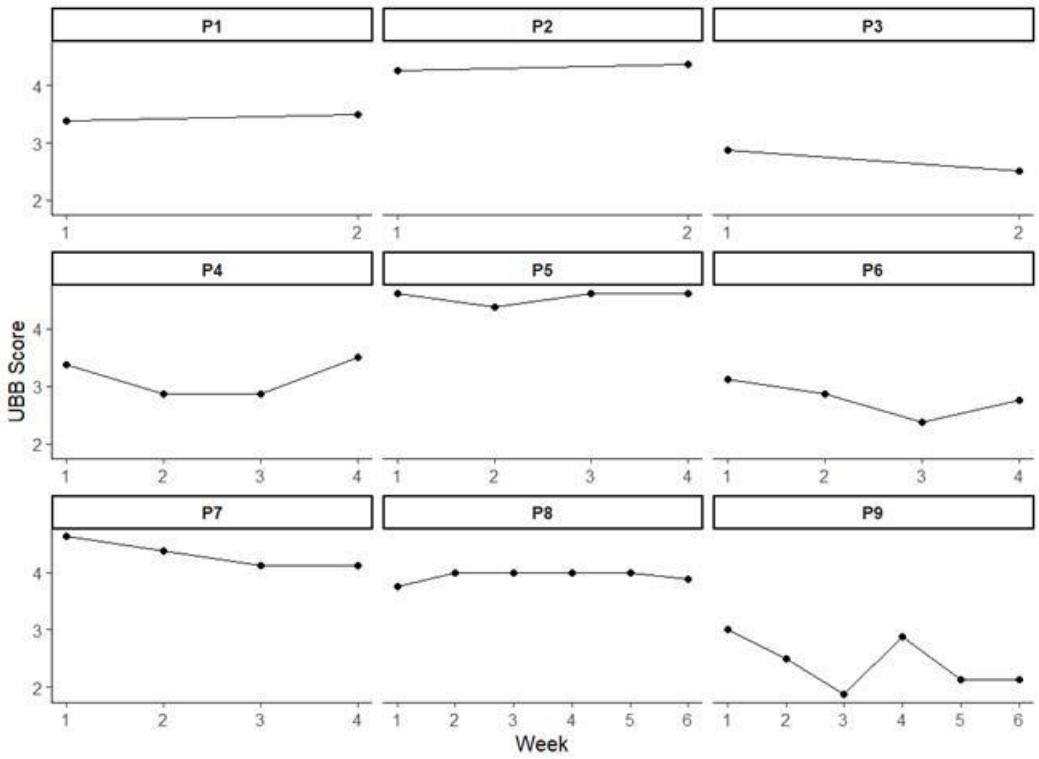


Figure 4.1. Participants' Baseline Phase Scores

4.3. Visual Analysis of Unfinished Business Tension

Regarding the primary outcome, Figure 4.2. graphically depicts the trajectories of unresolved business (UBBS) scores for all nine participants across baseline, intervention, and follow-up phases. Visual analysis showed that UBBS scores were stable irrespective of baseline length (2, 4, or 6 weeks) across all patients. Essentially, after the introduction of the Islamically integrated chair-work intervention (session 3), UBBS scores decreased consistently. During treatment, UBBS scores decreased for 7 of 9 participants (excluding P4 and P9), and all fell below the study's determined cutoff. During the follow-up period, reductions were sustained; no one returned to baseline levels, providing strong evidence for the intervention's efficacy and durability.

In addition, nearly half of the participants (P1, P2, P3, P8) showed a dramatic reduction in UBBS scores after the chair-work intervention. Especially, P2’s baseline average decreased from 4.3 to 2.7 during the treatment and sustained at 2.5 at follow-up. Similarly, P8 demonstrated stability during the longest baseline (6 weeks) at around 3.9, and during the intervention, UBBS scores showed a sharp decline (around 2.0), then sustained through follow-up. This trajectory highlights both quick treatment response and long-term improvement.

Moreover, participants with a high UBBS score (P5 & P7) at the beginning showed steady, clinically meaningful improvements. UBBS scores in P5 started at ~4.6 at baseline, dropped to 3.4 during treatment, and ended at 2.9 at follow-up. Also, P7 started at ~4.3 at baseline, declined to 3.1 during the intervention, and ended at 2.9 at follow-up. The pattern suggested that although reductions were less abrupt, substantial clinical gains were achieved and maintained.

Although baseline fluctuations were observed in P9, UBBS scores dropped at post-intervention (from approximately 2.8 to 2.0) and remained low. This trajectory suggests that participants with an unstable baseline trajectory benefited reliably from the intervention.

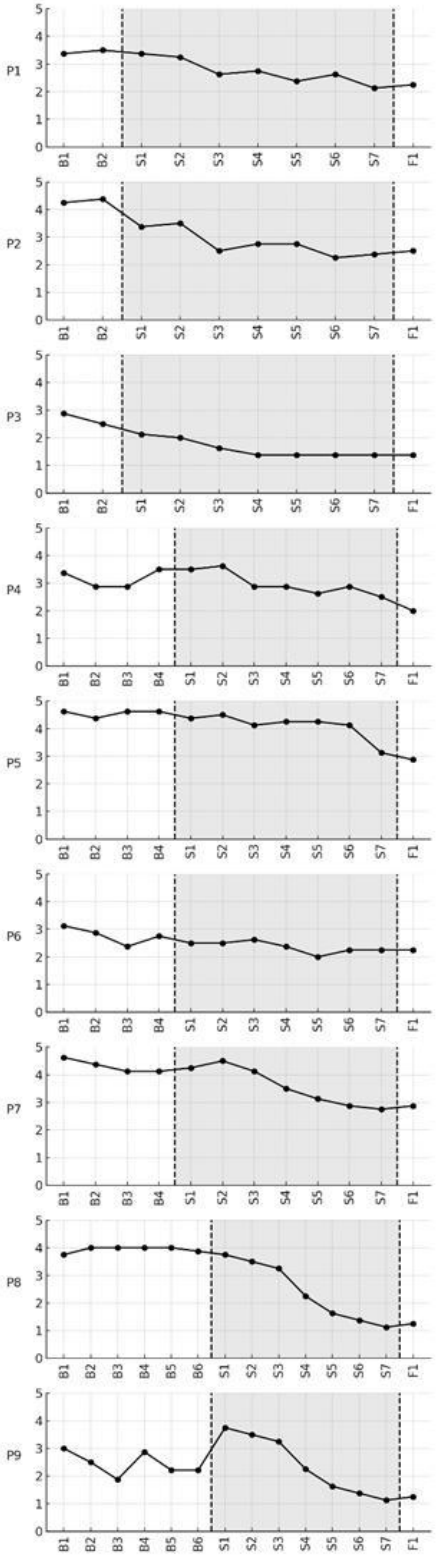


Figure 4.2. Weekly Unfinished Business Rating Scores Across Baseline, Treatment, and One-Month Follow-Up

Note. The gray portion represents the intervention phase.

4.4. Tau-U Results

Effect size estimates using Tau-U further confirmed large treatment effects across participants. Before estimating Tau-U, we examined within-baseline monotonic trends for each participant using Kendall's τ (two-sided tests). Consistent with single-case guidelines, we planned to apply Parker's baseline-trend correction only when the baseline showed a trend in the improvement direction (for UBBS, downward), of non-trivial magnitude ($|\tau| \geq .20$) with statistical support ($p < .10$), and based on a sufficient number of baseline observations (≥5). No baseline series met our a priori criteria for trend correction; therefore, no baseline-trend correction was applied. For P1–P3, the baselines contained only two observations (insufficient for reliable trend estimation). For P4–P5, τ was positive and non-significant (i.e., in the worsening direction for UBBS). For P6 and P9, τ was negative but non-significant. P7 showed a negative, marginal trend ($p = .089$) but with only four baseline data points, which did not meet the prespecified $n \geq 5$ criterion (see Table 4.4). In sum, correction was not warranted for any participant.

Table 4.4. Baseline Trend Tests (Kendall's τ) for UBBS and Decision on Parker Correction

Participant	Baseline *n*	Pairs	τ	Z	*p*	90% CI
P1	2	1	1.000	1.000	0.317	[-0.645, 1.000]
P2	2	1	1.000	1.000	0.317	[-0.645, 1.000]
P3	2	1	-1.000	-1.000	0.317	[-1.000, 0.645]
P4	4	6	0.167	0.340	0.734	[-0.640, 0.974]
P5	4	6	0.167	0.340	0.734	[-0.640, 0.974]
P6	4	6	-0.667	-1.358	0.174	[-1.000, 0.140]

Table 4.4. (cont.)

P7	4	6	-0.833	-1.698	0.089	[-1.000,-0.026]
P8	6	15	0.067	0.187	0.851	[-0.517, 0.650]
P9	6	15	-0.400	-1.127	0.260	[-0.984, 0.184]

Note. UBBS = Unfinished Business in Bereavement Scale. Negative τ denotes a downward (improvement) trend. Parker correction pre-specified when $\tau \leq -.20$, $p < .10$, and baseline $n \geq 5$. Baseline *n* = number of A-phase points. NS = non-significant. CI = confidence interval.

Visual inspection showed a clear post-intervention downward pattern in Unfinished Business (UBBS) for most participants. Participant-level Tau-U values indicated substantial intervention effects on UBBS. The mean Tau-U was 0.758 (median = 0.893; range = 0.25–1.00). At $\alpha = .05$, 5/9 participants (P2, P3, P5, P6, P8) showed statistically significant effects. Using 90% confidence intervals, 7/9 participants (P1, P2, P3, P5, P6, P7, P8) had intervals that did not include 0, indicating at least trend-level evidence of benefit. The largest effects were observed for P2, P3, and P8 (Tau-U ≈ 1.00), followed by P5 (Tau-U = 0.893) and P6 (Tau-U = 0.750). Effects were modest for P9 (0.452) and small for P4 (0.250). Overall, the pattern is consistent with a large, clinically meaningful reduction in unfinished business for most participants. Table 4.5 summarizes the Tau-U analysis for each participant.

Table 4.5. Participant-Level Tau-U for Unfinished Business (UBBS) with 90% Confidence Intervals

Participant ID	τ	*p*	90% CI	Effect Size Class
P1	0.929	0.0905	[0.714, 1.000]	Very large
P2	1.000	0.0472	[1.000, 1.000]	Very large
P3	1.000	0.0265	[1.000, 1.000]	Very large
P4	0.250	0.5880	[-0.286, 0.714]	Moderate
P5	0.893	0.0160	[0.643, 1.000]	Very large
P6	0.750	0.0440	[0.286, 1.000]	Large

Table 4.5. (cont.)

P7	0.571	0.1490	[0.034, 0.929]	Moderate
P8	0.976	0.0030	[0.905, 1.000]	Very large
P9	0.452	0.1980	[-0.024, 0.857]	Moderate

Note. UBBS = Unfinished Business in Bereavement Scale

Baseline trends were checked with Kendall's τ. No participant met the pre-specified criteria for Parker correction ($|\tau| \geq .20$, $p < .10$, baseline $n \geq 5$); thus, no correction was applied.

CI = confidence interval.

4.5. Emotional Arousal During Sessions

Emotional arousal during sessions was rated using the CEAS–III (1–7 scale). For each session (except session 1), two ratings were obtained and subsequently averaged to represent the typical level of emotional arousal for sadness. Session 1 was not included since it usually involves the client and therapist engaging with each other regarding the mechanics of therapy.

Table 4.6 summarizes descriptive statistics for CEAS–III scores across sessions. Emotional arousal was in the moderate range at session 2 (M = 3.00, SD = 1.46) and peaked during session 3 (M = 4.44, SD = 1.18), suggesting that participants reached their highest levels of emotional activation shortly after the introduction of TIIP chair-work interventions. From session 4 onwards, CEAS–III scores gradually declined: Session 4 remained moderate (M = 3.50), while sessions 5 and 6 showed lower levels (M = 3.22 and M = 2.28, respectively). By session 7, emotional arousal had dropped into the low range (M = 1.67, SD = 0.97).

Table 4.6. Descriptive Statistics for CEAS–III Scores Across Sessions

Session	M	SD	Min	Max
2	3	1.46	1.5	5
3	4.44	1.18	2.5	6
4	3.50	1.46	2	6
5	3.22	1.28	2	5

Table 4.6. (cont.)

6	2.28	1.18	1	5
7	1.67	0.97	1	4

Note. CEAS – III = Clinical Emotional Arousal Scale – III (1–7). Scores represent therapist ratings of participants' emotional arousal during each session.

Figure 4.3 shows individual participant trajectories that symbolize the variability and commonality in the pattern of arousal. Even though each participant drew a different process, they mostly showed elevated arousal during the first phase, then lower levels toward the end of treatment.

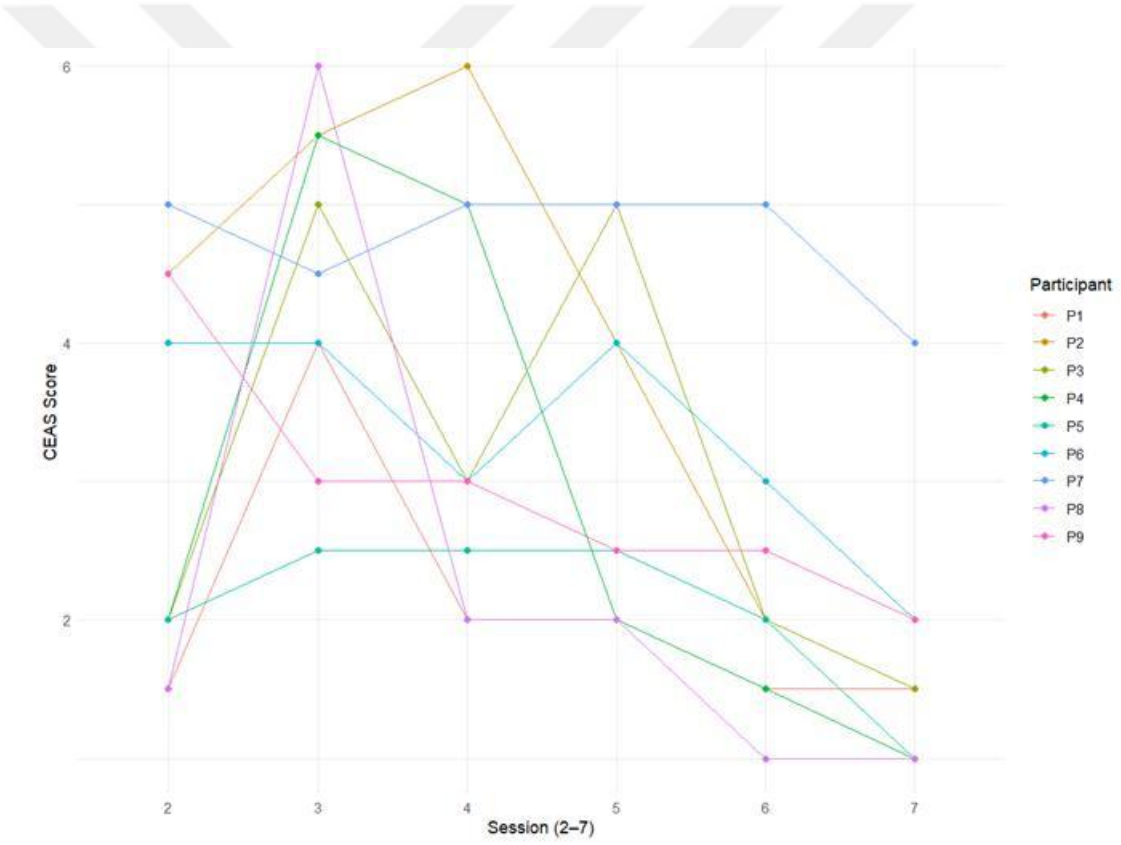


Figure 4.3. Individual Participant Trajectories of CEAS–III Scores Across Sessions

Figure 4.4 depicts the group-level CEAS–III trend, showing a peak in emotional arousal in session 3 and a consistent decrease thereafter. This trajectory signifies that the TIIP chair-work intervention initially elicited moderate-to-high emotional arousal,

particularly around session 3, which then diminished steadily across later sessions. This pattern is consistent with our hypothesis, indicating moderate emotional arousal followed by a reduction in the unfinished business.

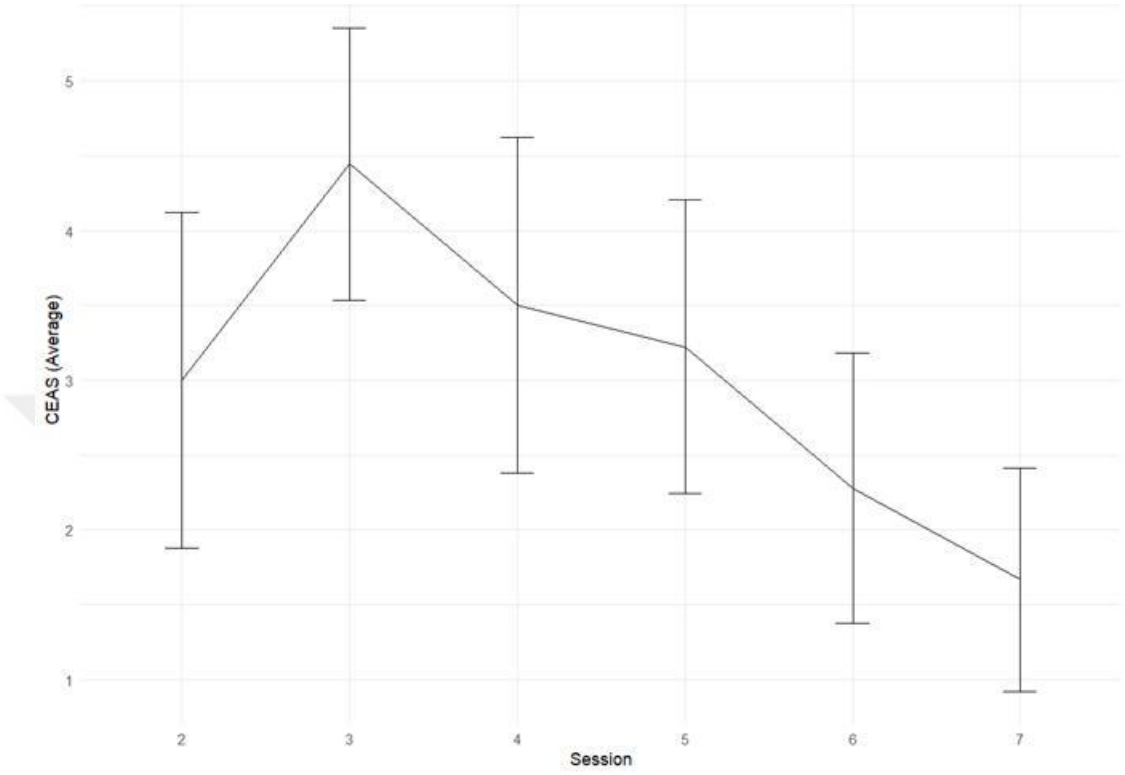


Figure 4.4. Group-Level CEAS–III Trend Across Sessions

To test hypothesis 2, associations between average CEAS–III scores and reductions in UBBS were examined (see Table 4.7). A mixed-effects model with random participant intercepts revealed significant session effects on CEAS–III scores. Compared to session 2 (M = 3.00), CEAS–III was significantly higher at session 3 (β = 1.44, SE = 0.47, p = .004) and significantly lower at session 7 (β = –1.33, SE = 0.47, p = .007). No significant differences were observed at sessions 4 – 6. This indicates that emotional arousal peaked in the early intervention phase (session 3) and decreased toward the final session. These results provide support for the hypothesis that moderate levels of emotional arousal are linked to reductions in unfinished business among bereaved participants.

Table 4.7. Linear Mixed-Effects Model Predicting CEAS–III Scores from Session

Predictor	Estimate (β)	SE	df	t	p
Intercept (Session 2)	3.00	0.42	28.10	7.11	< .001
Session 3	1.44	0.47	40.00	3.07	.004
Session 4	0.50	0.47	40.00	1.06	.295
Session 5	0.22	0.47	40.00	0.47	.640
Session 6	–0.72	0.47	40.00	–1.53	.133
Session 7	–1.33	0.47	40.00	–2.83	.007

Note. CEAS – III = Clinical Emotional Arousal Scale – III (1–7). Estimates are unstandardized fixed effects with Session 2 as the reference category.

4.6. Wilcoxon Test Results

Nonparametric comparisons were conducted to examine pre-, post-, and post–follow–up differences. Table 4.8. summarizes the Wilcoxon Signed-Rank Test Results of the scales. Unfinished Business tension decreased significantly from pre (Mdn = 2.62) to post (Mdn = 2.25), $Z = 2.26$, $p = .028$, indicating a very large effect. The reduction was maintained at follow-up, $Z = 2.21$, $p = .030$, (Mdn = 2.62; 2.25), again very large. However, there is no significant change between post (Mdn = 2.25) and follow-up (Mdn = 2.25) measurements ($Z = -0.34$, $p = .796$). These results supported our hypothesis (H1), which, as was expected, showed immediate and sustained reductions of very large magnitude in unfinished business tension.

In terms of prolonged grief symptoms, median scores fell from pre (Mdn = 46) to post (Mdn = 40) and from pre (Mdn = 46) to follow-up (Mdn = 40). However, neither change reached significance (pre–post: $Z = 1.44$, $p = .155$; pre–follow-up: $Z = 1.33$, $p = .191$). No change was detected from post (Mdn = 40) to follow-up (Mdn = 40). Effect sizes are medium to approaching large, suggesting improvement that did not achieve statistical significance with this sample. The hypothesis (H3) couldn't be supported.

A Wilcoxon signed-rank test indicated that there was no significant difference in grief cognitions from pre-test (Mdn = 58, $Z = 1.14$, $p = .262$) to post-test (Mdn = 52), $Z = 1.14$, $p = .262$, and from post-test (Mdn = 52) to follow-up (Mdn = 44), $Z = 1.01$, $p = .343$. By follow-up, the reduction became significant, with a large effect size (Z = 2.03, p = .044; Mdn = 58; 44). Regarding broader symptomatology, the pattern provides qualified support for the hypothesis (H4).

Depression symptoms didn't immediately change from pre-test (Mdn = 17) to post-test (Mdn = 16), $Z = 0.142$, $p = .888$. However, a significant and very large reduction emerged by follow-up (pre–follow-up Mdn = 17; 8, Z = 2.53, p < .05, r = .849; post–follow-up Mdn = 16; 8, $Z = 2.19$, $p < .05$, r = .731). A Wilcoxon signed-rank test indicated that there was no significant difference in anxiety symptoms from pre-test (Mdn = 12) to post-test (Mdn = 11), $Z = 0.17$, $p = .932$. By follow-up, the reduction was significant, with a very large effect from pre-test Z = 2.11, p < .05 (Mdn = 12; 10), and post-test Z = 2.2, p < .05 (Mdn = 11; 10).

Table 4.8. Wilcoxon Signed-Rank Test Results

Scale	Comparison	n (pairs)	Pre/Post Median	Post/ Follow-up Median	*V*	*Z*	*p*	*r*
UBBS	Pre–Post	8	2.62	2.25	34	2.26	.028*	.797
UBBS	Pre–Follow-Up	8	2.62	2.25	34	2.21	.030*	.781
UBBS	Post–Follow-Up	7	2.25	2.25	12	-0.34	.796	.128
PG-13	Pre–Post	9	46	40	35	1.44	.155	.479
PG-13	Pre–Follow-Up	9	46	40	34	1.33	.191	.443
PG-13	Post–Follow-Up	9	40	40	16	0.34	.799	.128
GCQ	Pre–Post	8	58	52	26.5	1.14	.262	.402
GCQ	Pre–Follow-Up	9	58	44	40	2.03	.044*	.677
GCQ	Post–Follow-Up	9	52	44	31	1.01	.343	.336
PHQ-9	Pre–Post	8	17	16	19.5	0.21	.888	.074
PHQ-9	Pre–Follow-Up	9	17	8	44	2.55	.013*	.849
PHQ-9	Post–Follow-Up	9	16	8	41	2.19	.032*	.731

Table 4.8. (cont.)

GAD-7	Pre–Post	7	12	11	15	0.17	.932	.064
GAD-7	Pre–Follow-Up	7	12	10	26.5	2.11	.041*	.799
GAD-7	Post–Follow-Up	7	11	10	27	2.2	.034*	.831

Note. V = Wilcoxon signed-rank statistic. Two-sided p-values are reported. UBBS = The Unfinished Business in Bereavement Scale. PG-13 = Prolonged Grief Disorder-13 Scale. GCQ = Grief Cognitions Questionnaire. PHQ-9 = Patient Health Questionnaire-9. GAD-7 = Generalized Anxiety Disorder-7

4.7. Reliable Change Index (RCI)

RCI analysis was used to evaluate individual-level change. Clinical significance was assessed using the Jacobson and Truax method. Table 4.9. summarizes the results of the RCI and clinical significance for each participant across all scales. Several participants demonstrated reliable improvement on the outcome measures, with scores exceeding the threshold for measurement error. Using the Jacobson–Truax Reliable Change Index ($|RCI| \geq 1.96$), four participants demonstrated reliable improvement on PG-13 (P1, P2, P3, P8), one showed reliable deterioration (P4), and four showed no reliable change. For grief cognitions (GCQ), reliable improvement was observed in two participants (P1, P2), and deterioration in one (P5). Anxiety (GAD-7) showed reliable improvement in two participants (P2, P3) and deterioration in one (P8). For depression (PHQ-9), no reliable improvements were detected; two participants (P7, P9) showed reliable deterioration, and seven showed no reliable change.

For the primary outcome (UBBS), two participants (P2, P8) exhibited reliable improvement, and seven showed no reliable change. Taken together with large Wilcoxon effects at follow-up and very-large Tau-U effects for UBBS, these results indicate that chair-work produced robust reductions at the group and single-case levels, with reliably large individual gains for a subset of participants, consistent with the hypothesized mechanism of change under moderate emotional arousal.

Table 4.9. Reliable Change Index (RCI) and Clinical Significance (Jacobson & Truax Method)

Participant	Scale	Pre-score	Post-score	RCI	Clinically Significant Change (Yes/No)
P1	UBBS	2.625	2.125	-1.7857143	No reliable change
	PG-13	51	42	-2.0104507	Reliable improvement
	GCQ	106	79	-2.3254425	Reliable improvement
	PHQ-9	19	16	-0.8623253	No reliable change
	GAD-7	11	11	0.0000000	No reliable change
P2	UBBS	4.000	2.375	-5.8035714	Reliable improvement
	PG-13	51	40	-2.4572176	Reliable improvement
	GCQ	113	69	-3.7896100	Reliable improvement
	PHQ-9	17	12	-1.4372089	No reliable change
	GAD-7	15	8	-2.1323092	Reliable improvement
P3	UBBS	1.875	1.375	-1.7857143	No reliable change
	PG-13	34	23	-2.4572176	Reliable improvement
	GCQ	39	26	-1.1196575	No reliable change
	PHQ-9	11	7	-1.1497671	No reliable change
	GAD-7	15	7	-2.4369248	Reliable improvement
P4	UBBS	2.625	2.500	-0.4464286	No reliable change
	PG-13	46	74	6.2547356	Reliable deterioration
	GCQ	65	74	0.7751475	No reliable change
	PHQ-9	19	16	-0.8623253	No reliable change
	GAD-7	15	15	0.0000000	No reliable change
P5	UBBS	3.000	3.125	0.4464286	No reliable change
	PG-13	44	43	-0.2233834	No reliable change
	GCQ	58	90	2.7560800	Reliable deterioration
	PHQ-9	19	20	0.2874418	No reliable change
	GAD-7	9	12	0.9138468	No reliable change
P6	UBBS	2.250	2.250	0.0000000	No reliable change
	PG-13	49	44	-1.1169171	No reliable change
	GCQ	53	46	-0.6028925	No reliable change
	PHQ-9	12	11	-0.2874418	No reliable change
	GAD-7	14	13	-0.3046156	No reliable change

Table 4.9. (cont.)

P7	UBBS	3.250	2.750	-1.7857143	No reliable change
	PG-13	39	33	-1.3403005	No reliable change
	GCQ	52	52	0.0000000	No reliable change
	PHQ-9	5	13	2.2995342	Reliable deterioration
	GAD-7	12	11	-0.3046156	No reliable change
P8	UBBS	3.500	1.125	-8.4821429	Reliable improvement
	PG-13	49	13	-8.0418029	Reliable improvement
	GCQ	65	46	-1.6364225	No reliable change
	PHQ-9	20	20	0.0000000	No reliable change
	GAD-7	9	19	3.0461560	Reliable deterioration
P9	UBBS	1.750	1.625	-0.4464286	No reliable change
	PG-13	35	39	0.8935337	No reliable change
	GCQ	53	44	-0.7751475	No reliable change
	PHQ-9	9	16	2.0120925	Reliable deterioration
	GAD-7	6	7	0.3046156	No reliable change

Note: UBBS = The Unfinished Business in Bereavement Scale. PG-13 = Prolonged Grief Disorder-13 Scale. GCQ = Grief Cognitions Questionnaire. PHQ-9 = Patient Health Questionnaire-9. GAD-7 = Generalized Anxiety Disorder-7

CHAPTER V

DISCUSSION

5.1. Overview of Findings

This study was designed to develop the TIIP grief protocol to address unfinished business in patients with prolonged grief and to evaluate its effectiveness. To assess the protocol's effectiveness, a range of analytical strategies was employed. Results consistently demonstrated that the TIIP-based grief protocol made a significant contribution to clinical improvement in bereaved Muslim participants.

Unfinished business tension decreased substantially after the introduction of the chair-work intervention in the third session and continued to decline steadily until the end of the psychotherapy protocol. At the end of the psychotherapy process, prolonged grief symptoms and maladaptive grief cognitions decreased markedly. In contrast, changes in general psychological distress (anxiety and depression) were less consistent —some participants experienced reductions, whereas others remained stable. Follow-up measurements revealed that the grief-related therapeutic changes during the psychotherapy were sustained even one month later.

Taken together, these findings provide preliminary support for the feasibility and potential efficacy of the TIIP-based protocol in grief therapy, in terms of both statistically and practically meaningful improvements in bereaved Muslim clients struggling with unfinished business.

5.2. Chair-Work Effects on Unfinished Business

Unfinished business tension, as measured by the UBBS, was the domain of the most consistent change across participants. Given that resolving unfinished business represented the central therapeutic target of the intervention, the following section

examines these findings in greater depth. By integrating visual inspection of multiple baselines with Tau-U statistics, the analysis provides both clinical and statistical evidence that the introduction of chair-work supports the first hypothesis and that there are meaningful reductions in unfinished business scores.

Consistent with the first hypothesis, participants demonstrated substantial reductions in unfinished business following the introduction of chair-work. The results confirm the hypothesis that the Islamically integrated chair-work intervention reduces the degree of unfinished business compared to the baseline phase. This finding aligns with the earlier study showing that if unresolved grief is unaddressed, it predicts long-term psychological distress (Field & Horowitz, 1998). This study shows that specifically addressing unfinished business through chair-work serves as a preventive strategy and fosters healthier adjustment. In light of these, the hypothesis was confirmed, and the study demonstrates the effectiveness of the TIIP-based chair-work interventions on the grief-related issues.

These findings also showed that therapeutic gains obtained during the psychotherapy were sustained over time. Follow-up assessments demonstrated that unfinished business scores remained well below baseline levels and closely aligned with post-treatment values. Importantly, no participant returned to their baseline trajectory, and reductions were maintained regardless of initial symptom severity or baseline stability. In addition, even the patient (e.g., P9) with fluctuating baseline patterns showed a significant reduction in UBBS scores after the chair-work intervention, and these scores were sustained at one-month follow-up. This pattern suggests that the intervention not only facilitated short-term symptom relief but also produced durable benefits, highlighting its potential to support long-term adjustment in bereaved Muslims experiencing prolonged grief. Successful empty chair dialogue predicting long-term adjustment.

Chair-work interventions, particularly the empty-chair dialogue, developed initially in Gestalt therapy by Fritz Perls (1951), are specifically designed to reduce and resolve unfinished business with a significant other (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). In this regard, the therapeutic outcome of a study involving 26 clients with interpersonal problems was linked to the resolution

of unfinished business through emotion-focused therapy and empty-chair dialogues, findings consistent with our study (Greenberg & Malcolm, 2002). Clients who expressed unmet needs and shifted their view of the other experienced better treatment outcomes (Greenberg & Malcolm, 2002). When we consider the opposite side of the unresolved unfinished business, which is accepted as one of the most significant manifestations of being "stuck" in the face of death (Perls, 1951). Considering that the empty chair dialogue is used in the psychotherapy process to resolve patients' stuck points. Moreover, in another study, 34 clients with unresolved feelings in a significant other relationship were assigned to experiential therapy or psychoeducational therapy, with the latter offering information about "unfinished business." Results showed significant clinical gains, with experiential therapy showing greater improvement on all outcome measures, including general symptomatology, interpersonal distress, target complaints, and specific measures of unfinished business, than psychoeducational therapy and maintaining these gains at follow-up (Paivio & Greenberg, 1995).

One possible explanation for the sustained therapeutic gains observed at the one-month follow-up lies in the experiential mechanisms activated by chair-work. This intervention deliberately evokes and processes emotions in vivo, enabling change through a "bottom-up" mechanism rather than relying solely on cognitive restructuring. Unfinished business in grief is often maintained by patterns of experiential and behavioral avoidance, which prevent the bereaved from engaging directly with the pain of loss (Boelen et al., 2006; Simon et al., 2007). Such avoidance perpetuates the sense of incompleteness and hinders emotional resolution. By contrast, chair-work dialogues provide a safe and structured context in which clients confront avoided aspects of their grief –such as the absence of their loved one, the need to say goodbye, or the construction of a life without them. The sustained decline in UBBS at follow-up underscores the durability of these changes, suggesting that once avoidance was overcome and unmet needs were addressed, participants carried these gains forward into daily life.

This underlying mechanism is reflected in the loss phase of our grief protocol. The loss phase is designed to help clients shift their perspective from viewing the relationship with the deceased to recognizing a continuing psychological bond that

transcends physical absence. This conceptualization resonates with al-Kindî's philosophical reflections on loss, in which he argued that attachment to the physical body is transient, whereas the connection to the essence or memory of the loved one endures. In this sense, the therapeutic process does not merely emphasize separation but rather facilitates a reorientation of the bereaved toward an enduring, internalized connection, thereby promoting both emotional integration and long-term resilience. By grounding the client in a bond that is not dependent on the deceased's physical presence, the intervention provides a stable framework that helps sustain therapeutic gains beyond the active treatment phase.

From the theoretical perspective, these results fit with contemporary grief models. Resolved unfinished business tension can be considered a facilitator of sustained continuing bonds (Klass et al., 1996), in which the relationship between the deceased and the bereaved is not detached but transformed into an internalized and adaptive connection. In a similar manner, the Dual Process Model was supported, with unresolved unfinished business may create a space for more flexible oscillation between loss-oriented and restoration-oriented coping (Stroebe & Schut, 1999). Importantly, the TIIP framework extends these models by embedding Islamic philosophical perspectives.

From the Islamic perspective, this process could be considered effective. Throughout the interventions, therapists guided clients by emphasizing the unbreakable bond between them, that the reality of separation is a part of divine decree (qadar). This reflects the classical Islamic thought. For example, Al-Kindî emphasized that channeling emotional pain of loss via reflection of divine wisdom and the unavoidability of loss (al-Kindî, trans. Jayyusi-Lehn, 2012). In parallel, Ibn Qayyim al-Jawziyya defined grief and yearning as natural reactions but also emphasized that extreme attachment may hinder sabr (patience) and spiritual growth (Pajević et al., 2021). Facing avoided grief themes in dialogue allowed participants to align their emotional experience with these spiritual frameworks of acceptance (sabr) and surrender (tawakkul).

The main factor underlying the mechanism of the observed and sustained grief-related improvements is the holistic healing perspective of the TIIP framework, which

conceives of health as both psychological and spiritual (Qalb Salîm). While previous studies have demonstrated the success of secular emotion-focused therapies, the current study revealed the efficacy of a religiously sensitive protocol. From a holistic perspective, even though the problem is conceptualized as an emotional burden, integrating emotional exposure and religious meaning-making led to behavioral and cognitive changes beyond therapy sessions. The metaphysical aspects of human needs and drives form an essential part of TIIP's ontological model of the human being (Keshavarzi et al., 2020). In light of that, TIIP grief protocol addresses both psychological and religious needs of bereaved individuals via facilitating emotional transformation, discovering meaning, and activating behavioral change.

Saying goodbye, expressing unspoken words, and acknowledging the loved ones' absence in a contained environment fostered both emotional release and religiously meaningful reframing (Tobin, 1971). This integration may explain why reductions in unresolved business were not only achieved during treatment but also preserved at follow-up: clients did not merely suppress or rationalize their pain but transformed it into a spiritually coherent narrative. In this way, the intervention facilitated durable change by linking emotional processing with Islamic meaning-making, which can serve as a long-term anchor for grief adaptation.

5.3. Emotional Arousal

In this study, the analysis of CEAS scores across sessions provided important insights into the role of emotional arousal during therapy. Consistent with hypothesis 2, participants demonstrated moderate levels of arousal in the early sessions, peaking at session 3, followed by a steady decline toward the final session. This trajectory suggests that the intervention effectively elicited moderate emotional activation at a clinically productive level, which enabled participants to engage with emotionally charged material. The subsequent reduction in arousal appears to coincide with the resolution of unfinished business, indicating that once core interpersonal themes were processed, emotional intensity naturally subsided.

The reduction in UBBS scores appears to have been driven by core in-session processes identified in models of resolution. According to EFT and Gestalt

approaches, successful resolution of unfinished business involves emotional arousal and expression, the mobilization of unmet needs, and shifts in the perception of self and other (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). The empty chair dialogue is a powerful tool for facilitating the full expression of previously suppressed emotions (Greenberg, 1993). Empirical evidence indicates that clients who experience more intense affect during the dialogue are more likely to be classified as "resolvers" and to demonstrate superior therapeutic outcomes (Greenberg & Malcolm, 2002). Accessing emotion is thought to activate associative networks of memories and beliefs, thereby rendering them available for restructuring. A central assumption in EFT is that unresolved experiences must be enacted and emotionally processed rather than discussed solely at a cognitive or intellectual level (Pos, Greenberg, & Goldman, 2003; Greenberg & Foerster, 1996; Greenberg & Malcolm, 2003; Paivio & Greenberg, 1998; Shahar et al., 2012).

From a theoretical perspective, these findings support models of psychotherapy process that emphasize an optimal zone of emotional arousal (e.g., Greenberg, 2017). Emotional arousal is considered a central mechanism of change across psychotherapeutic approaches because it activates complex emotional schemes – integrated constellations of perceptions, bodily sensations, cognitions, and affect – that become available for exploration and restructuring (Stiegler et al., 2018; Sutherland et al., 2014; Tobin, 1971). In our protocol, the TIIP chair-work phase was designed to evoke emotions within a structured and safe environment. As part of the inkishaaf process, patients are guided to imagine and re-experience their lost loved one, with the therapist assisting them in moving beyond merely talking about emotions toward directly experiencing them (see Figure 3.2). Studies have further shown that chair-work interventions are more effective in decreasing emotional experiencing and facilitating resolution than interventions that rely exclusively on empathic reflection or cognitive problem-solving (Clarke & Greenberg, 1986; Stiegler et al., 2018).

The clinical objective is to achieve a level of arousal sufficiently high to enable emotional experiencing but not so hşgh as to overwhelm the client's reflective capacity. For example, moderate arousal (typically rated as 4 or higher on a 7-point scale) is regarded as optimal for therapeutic work, whereas excessively low or excessively high arousal tends to be less productive (Pascual-Leone & Baher, 2023).

Visual inspection of the multiple-baseline graphs suggested that reductions in UBBS scores typically coincided with sessions in which clients displayed moderate emotional arousal. In contrast, sessions characterized by predominantly şow arousal were associated with limited change, while high arousal occasionally coincided with temporary increases in distress.

This principle follows an "inverted-U" function: both insufficient and excessive arousal impede therapeutic change, while moderate levels foster adaptive emotional processing. The present findings illustrate this principle. Emotional arousal was neither persistently low, which might have reflected avoidance, nor excessively high, which could have risked dysregulation. Instead, participants engaged with sufficient emotional intensity to access and transform painful material, followed by a natural decline in arousal as therapeutic goals were accomplished.

As illustrated in Figure 5.2.1, arousal peaked at Session 2 within the moderate-to-high range and declined in subsequent sessions. This pattern provides empirical support for Hypothesis 2, suggesting that the intervention facilitated an initial phase of optimal emotional activation, which in turn contributed to the gradual resolution of unfinished business and the reduction of associated tension over time. CEAS therefore emerges as a valuable process measure for capturşng this mechanism of change.

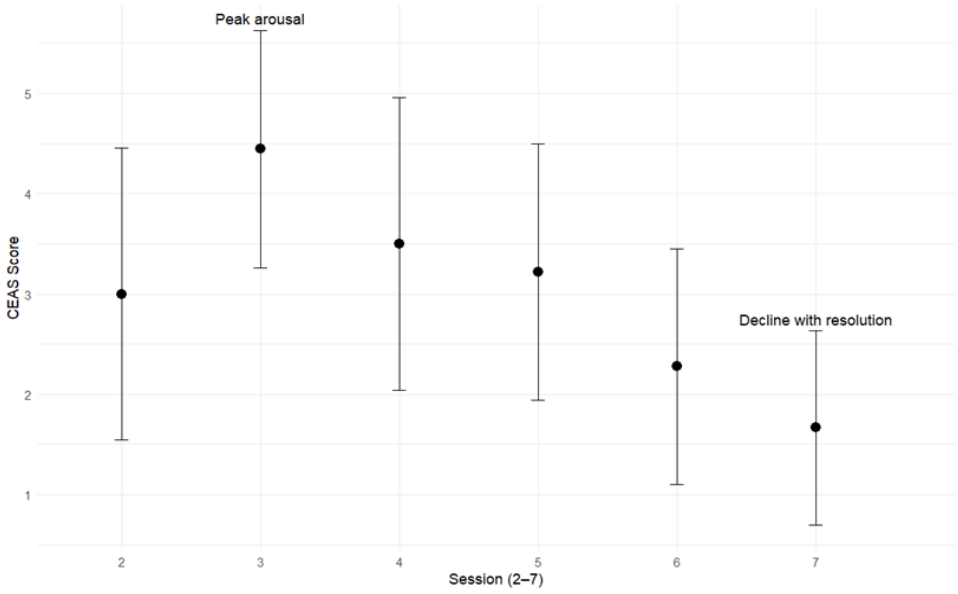


Figure 5.1. Grouped CEAS Scores Per Session

Another component of the resolution model is the mobilization of unmet needs and the resulting shifts in the perception of self and other (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). The TIIP protocol was designed with this principle in mind. Specifically, the chair-work phase incorporated grief meditation perspectives inspired by al-Râzî, and – following the inkishâf process – helped patients to achieve i'tidal (emotional regulation and emotional transformation) by mobilizing unmet needs through understanding, forgiveness, or a change in their view of the deceased (see Figure 3.2). Within the dialogue, patients shifted roles between themselves and the deceased, openly expressing thoughts and feelings. Therapists facilitated this process by fostering awareness through nonverbal cues, empathic conjectures, and guided reflections.

Therapists supported patients in imagining the deceased's perspective, aware of relationship limitations, then engaging in corrective emotional experiences. When patients expressed their primary emotional experience, such as anger or sadness, they were able to access and express deeper unmet needs, such as a need for validation, love, or safety (Field & Horowitz, 1998; Greenberg & Malcolm, 2002; Watson et al., 2011). This strategy aligns with al-Râzî's emphasis that sorrow can be moderated when individuals consider their limited control, shift their perspective, and channel their emotions toward what is within their agency (Pajević et al., 2021). Similarly, al-Kindî in *The Device for Dispelling Sorrows* highlighted that grief arises from attachment to what is impermanent, and he proposed that relief comes from reframing loss as an inevitable aspect of human existence (al-Kindî, trans. Jayyusi-Lehn, 2002). Within the TIIP protocol, such reframing was facilitated by encouraging patients to move beyond the sense of relational disconnection and recognize an enduring psychological and spiritual bond with the deceased, transcending the physical absence.

The articulation of unmet needs is recognized as a central mechanism of resolution (Greenberg & Malcolm, 2002). Ultimately, successful resolution is marked by a shift in the client's perception of both themselves and the deceased, a transformation consistently identified in the literature as critical for adaptive emotional processing (Greenberg &Malcolm, 2002; Lampropoulos & Nicholas, 2001; Paivio & Greenberg, 1995). In the TIIP framework, this transformation is reinforced by drawing on Islamic philosophical perspectives – alRâzî's call to moderate sorrow through rational

reappraisal and al-Kind'i's insistence on reframing attachment in light of the inevitability of loss – thereby deepening and sustaining therapeutic change.

5.4. Reduction in Prolonged Grief Symptoms

The second hypothesis, predicting reductions in prolonged grief symptoms, was not supported. Wilcoxon signed-rank tests revealed a non-significant decrease in PG-13 scores from pre- to post-interventions (V = 35, p = .115). RCI analysis further confirmed reliable improvement for several participants, with some achieving scores below the clinical threshold at follow-up. These findings indicate that the Islamically integrated chair-work intervention contributed not only to a reduction in unfinished business but also to clinically meaningful improvement in prolonged grief symptoms.

A growing body of evidence demonstrates that grief-focused psychotherapies are effective in reducing prolonged grief, particularly among individuals with clinically significant symptoms (Treml et al., 2020). Across modalities, interventions commonly target avoidance, maladaptive cognitions, and emotional dysregulation, helping clients integrate loss-related memories into autobiographical narratives (Eisma & Stroebe, 2021). Evidence-based approaches share core therapeutic procedures – such as exposure or revisiting tasks, cognitive restructuring, and behavioral activation or restoration activities – yet they differ in format, duration, and emphasis. Randomized trials and meta-analyses consistently identify grief-specific psychotherapies and grief-focused cognitive behavioral therapies as the most effective interventions (Komischke-Konnerup et al., 2024; Shear et al., 2016).

Manualized protocols such as Prolonged Grief Disorder Therapy (PGDT; Reynolds et al., 2023; Shear et al., 2016), Complicated Grief Treatment (CGT; Iglewicz et al., 2020), internet-based programs assisted by therapists (Kaiser et al., 2022; Lenferink et al., 2020; Reistma et al., 2023), and mind-body focused procedures (Knowles et al., 2021) consistently demonstrate that targeting emotional processing and facilitating exposure to loss-related cues are central mechanisms of therapeutic change. This study aligns with these mechanisms. The TIIP protocol directly engages the emotional core of unfinished business by inviting clients to safely access and express intense emotions through chair-work. This experiential emotional activation parallels the exposure-

based and emotion-focused components of established grief treatments. However, TIIP extends these mechanisms by embedding them within an Islamic meaning-making framework.

The efficacy of the present protocol could be clarified by the interventions systematically addressing components that are identified as therapeutic in the literature via structured phases. First of all, during the inkishâf phase, emotional interventions were utilized to reduce emotional avoidance and help emotional regulation. Secondly, the chair-work dialogue was used to explore unmet needs and egging with corrective emotional experience in the itidâl phase (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). Lastly, during the ittihad phase, cognitive consolidation and spiritually based behaviors supported the meaning-making process, which is an important key to adaptation in the bereavement period (Currier et al., 2006; Maccallum & Bryant, 2013). Taken together, these sequential components provided both experiential depth and cognitive-spiritual consolidation, which may explain the sustained reduction of prolonged grief symptoms observed at follow-up.

Unlike existing manualized grief therapies, however, the TIIP protocol uniquely integrates Islamic perspectives on meaning-making – such as reframing loss through qadar (divine decree) and reinforcing the continuing bond via religious practices – thereby enhancing cultural and spiritual relevance for Muslim clients.

5.5. Cognitive Adaptation

Changes in grief cognition partially supported the third hypothesis. For some participants, RCI analysis shows reliable improvement and a significant reduction in GCQ. These results suggest that the protocol is not just effective in reducing unfinished business tension but also in promoting more adaptive cognitive engagement during the bereavement period.

After the loss of a loved one, bereaved individuals commonly suffer from repetitive, maladaptive cognitions like self-blame, persisting yearning, or rumination about loss, which in turn increases the PGD symptoms (Knowles et al., 2021). The final phase of the TIIP protocol was specifically designed to address this maladaptive process.

Following the emotional intervention, cognitive-focused strategies were utilized to transform emotionally expressed unmet needs into a more adaptive understanding. Furthermore, a spiritual behavioral plan is supplemented to guide patients to an integrated meaning-making practice within the Islamic roots. This reflects the understanding that unfinished business is not solely about past relational conflict but also about the bereaved person's current cognitive and emotional attachment to the deceased (Tamanaha, 2005).

Meaning-making process is the central mechanism of this phase. Failure to engage in meaning-making is reported as a key feature of grief cognitions and complicated grief (Currier et al., 2006; Maccllum & Bryant, 2013). In the TIIP framework, emotional experiences cannot be separated from the mental and spiritual domains; thus, a metaphysical perspective is included in the conceptualization of the psyche. In light of these, the protocol provides space for therapist-guided cognitive reframing and for planning spiritually based actions such as prayer, reciting the Qur'an, grave visitation, giving charity, or repaying debts. These activities reinforced cognitive shifts by linking them to lived practices, thereby bridging insight with action.

The dual emphasis on cognitive and spiritual restructuring is important because, in the bereavement process, individuals may face struggles with core schemas (Maccllum & Bryant, 2013). In some cases, bereaved individuals could experience spiritual crisis, referred to as complicated spiritual grief (CSG), in which individuals experience detachment from faith or feeling anger toward the divine (Burke & Neimeyer, 2014). Such spiritual struggles represent a form of maladaptive grief cognition in themselves and are strongly associated with prolonged grief. By directly incorporating Islamic practices and theological reflection, the TIIP provided a framework for addressing these struggles, transforming spiritual anguish into opportunities for renewed connection and meaning. In doing so, the protocol's interventions not only alleviated maladaptive cognitions but also promoted resilience through culturally and spiritually grounded meaning-making.

5.6. Broader Psychological Well-Being

In the present study, depression and anxiety were evaluated as broader mental health conditions in addition to grief-related issues. Participants' broader psychological well-being status reflected mixed progress. While PHQ-9 and GAD-7 scores decreased for some participants, there is no uniform pattern across the sample. RCI analyses indicated that most changes did not reach the reliable improvement threshold, with only a small group of participants showing clear, reliable gains in terms of anxiety or depression symptoms.

These results could be explained in relation to the primary aim and the protocol's design. The TIIP protocol is specifically designed to address unfinished business tension in bereavement. Even some secondary benefits were observed from failure to report uniform improvement of the depression and anxiety symptoms, suggesting that the efficacy of the interventions is more pronounced in grief-related domains. Previous research reported similar results that unfinished business chair-work interventions predict a reduction in depression with partial and smaller magnitude compared to grief-specific outcomes (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1998). Moreover, research on complicated grief indicates that although grief-focused interventions may reduce comorbid depression and anxiety, such improvements are less robust than the reduction in grief symptoms themselves (Shear et al., 2005; Beolen et al., 2007)

Several factors may account for this discrepancy. First, depression and anxiety are multidimensional constructs with diverse etiologies; they are not always directly driven by unresolved grief, even in bereaved populations. Second, the relatively short duration of the intervention—seven sessions—may have limited the extent of change in more entrenched mood and anxiety symptoms, which often require longer treatment courses or disorder-specific interventions (Cuijpers et al., 2020). Third, the small sample size reduces the likelihood of detecting reliable individual-level change in secondary outcomes. Finally, it is possible that some participants required additional therapeutic components, such as behavioral activation for depression or exposure-based strategies for anxiety, which were beyond the scope of the present grief-focused protocol.

Taken together, these findings suggest that the TIIP grief protocol was most effective in reducing grief-specific processes such as unfinished business and maladaptive grief cognition. While some secondary benefits in depression and anxiety were observed, future research may explore integrating supplementary techniques or extending the treatment duration to maximize improvements in broader mental health domains.

5.7. Limitations

Several limitations of this study should be acknowledged. Firstly, the study's sample size is small, limiting the generalizability of the findings. Because of the nature of the bereavement period, reaching bereaved individuals is difficult. For this research, access to participants was further constrained by the difficulty of reaching individuals experiencing prolonged grief. Even though the reported results are promising, larger samples are needed to establish their robustness.

Secondly, the protocol consisted of a short number of sessions. While the findings suggest that the intervention was effective within this format, longer treatment protocols may allow participants to engage more fully with the therapeutic process. This is particularly relevant given that chair-work is one of the more demanding experiential techniques, requiring clients to sustain direct emotional engagement with the deceased. Bereaved individuals often avoid such encounters because of the pain they evoke, and in this study, participants were invited to face precisely what they had previously avoided since the loss. A longer preparatory or emphatic attunement phase may therefore provide additional support in facilitating readiness for such emotionally intense work.

Thirdly, all participants in this study were women. This reflects a broader trend in the literature, where women are more likely than men to seek psychological support and to participate in bereavement interventions. While this facilitated testing of the protocol, it also limits the ability to generalize findings to men, who may face greater challenges in engaging with emotionally focused interventions. Given that the TIIP protocol requires sustained emotional immersion, future studies should examine its applicability to men, who may have different help-seeking behaviors and coping styles.

Fourthly, the causes of death in this sample included COVID-19, cancer, and heart attacks. While these losses are significant, the protocol has not yet been tested with bereaved individuals facing disenfranchised or particularly stigmatized forms of grief, such as suicide bereavement. Existing research suggests that these groups may require additional or specialized therapeutic adaptations.

Finally, although three therapists delivered the intervention, variability in therapist style or skill was not systematically examined. While treatment fidelity was maintained through adherence to the protocol, future research should explicitly evaluate therapist effects to understand better whether and how therapist characteristics influence outcomes.

Despite these limitations, this study provides an essential first step in demonstrating the feasibility and potential efficacy of an Islamically integrated chair-work protocol for prolonged grief, laying the groundwork for future controlled trials.

5.8. Implications and Future Directions

The results of the present study have several clinical and theoretical implications; the findings also point to a clear direction for future studies. The current knowledge pointing out the unfinished business is an emotionally charged phenomenon, and emotional dysregulation problems have been revealed to play a key role in the onset and maintenance of PGD. The protocol provides ample space for emotion regulation strategies to support healing and reduce the risk of persistent PGD symptoms, in line with the literature (Wagner et al., 2006). It was recognized that difficulties in regulation –such as suppression or amplification of affect (Gupta & Bonanno, 2011), reduced emotional flexibility (Bonanno & Burton, 2013), and diminished expressive capacity (Diminich & Bonanno, 2014)– are strongly linked to greater severity of PGD symptoms (Cesur-Soysal & Durak-Batıgün, 2020).

Although the protocol draws upon established psychotherapeutic strategies, it simultaneously advances the field by incorporating Islamic principles and spiritual practices. This integration creates a culturally sensitive and spiritually resonant framework, positioning the intervention as both clinically and theologically

meaningful for Muslim patients. Prior literature underscores the critical role of spirituality in shaping grief responses and coping strategies; the present protocol extends this insight by embedding Islamic perspectives directly into the therapeutic process.

It is important to emphasize, however, that this protocol represents an initial step in intervention development. While it is informed by empirical research and grounded in both established and novel therapeutic principles, systematic clinical outcomes studies are required to test its efficacy rigorously. To date, no intervention has combined these specific therapeutic components with an explicit Islamic framework for Muslim patients experiencing prolonged grief. Future research should therefore focus on evaluating the protocol's strengths and limitations through controlled trials, with the ultimate goal of offering a validated, culturally adapted intervention that can be disseminated more broadly.

CHAPTER VI

CONCLUSION

The present study introduced and evaluated the TIIP grief protocol, designed to address the significant gap in the literature on prolonged grief treatment for Muslim patients. From both theoretical and clinical perspectives, this protocol advances the field of culturally adapted grief therapy by grounding its approach in an Islamic framework and translating this formulation into a session-by-session clinical structure. Drawing on the teaching of classical scholars such as al-Kindî, al-Râzî, and Ibn Sînâ, the protocol integrates religious and philosophical insight into contemporary psychotherapeutic practice, thereby offering a culturally and spiritually congruent response to the unique needs of bereaved Muslims.

Empirical findings provide preliminary evidence that Islamically integrated chair-work can effectively reduce unfinished business and grief-related distress. The multiple-baseline design, coupled with usual inspection, nonparametric statistics, and effect-size analysis, consistently demonstrated that unfinished business decreased following the introduction of chair-work. Statistically, this was reflected in significant reductions identified through Wilcoxon signed-rank tests and Tau-U analyses, while clinically, RCI calculations confirmed meaningful improvement for several participants. Visual analysis further highlighted that the decrease in unfinished business was 10 temporally aligned with the intervention, particularly between sessions 3 and 5, where emotional arousal was actively facilitated. Converging evidence across these analytic methods strengthens confidence in the observed improvements.

While these results are promising, they should be interpreted cautiously given methodological limitations, including a small sample size and limited participant characteristics. Nevertheless, the findings underscore the potential value of culturally and spiritually adapted experiential techniques in grief therapy. By directly addressing

unresolved emotions, fostering meaning-making, and promoting adaptive emotional orientations, the TIIP protocol offers a novel approach for facilitating patients' healthier grieving and enhancing emotional resilience.

Ultimately, this study provides an initial step toward the systematic development of Islamically integrated grief interventions. It highlights the feasibility and potential effects of combining experiential psychotherapy with Islamic philosophical and spiritual principles. Future research should seek to expand upon these findings through larger controlled trials, longer-term follow-up assessments, and applications to diverse bereaved populations. In doing so, the TIIP protocol may serve as both a clinical tool and a theoretical framework for advancing culturally sensitive approaches to grief therapy, contributing to a more inclusive and comprehensive science of bereavement.

REFERENCES

Abbasian, M., & Sahragard, M. (2024). The Effectiveness of Complicated Grief Treatment on Rumination, Emotion Regulation, and Coping Self-Efficacy in People with Prolonged Grief Disorder. *International Journal of Applied Behavioral Sciences*, *11*(2), 8–20. https://doi.org/10.22037/ijabs.v11i1.44715

Adamson, P. (2012). al-Kindī, Abū Yūsuf Yaʿqūb ibn Ishāq. *Encyclopedia of Medieval Philosophy*, *8*, 1–2.

Aksoz-Efe, I., Erdur-Baker, O., & Servaty-Seib, H. (2018). Death rituals, religious beliefs, and grief of Turkish women. *Death Studies*, *42*(9), 579–592. https://doi.org/10.1080/07481187.2017.1407379

al-Bukhari, M. I. (n.d.). *Sahih al-Bukhari*. In Sunnah.com. https://sunnah.com/bukhari

al-Bayjurî, A. (2002). Hâshiyat al-Imâm al- Bayjurî 'alâ Jawharat al-Tawhid. Cairo: Dâr al-Salâm

Al-Jawziyya, I. Q. (2020). *Ranks of the Divine Seekers Volume 2*. Brill.

AlMarri, T. S. K., Oei, T. P. S., & Al-Adawi, S. (2009). The development of the Short Muslim Practice and Belief Scale. *Mental Health, Religion & Culture, 12*(6), 551–563. https://doi.org/10.1080/13674670802637643

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders (5th ed., text rev.).* https://doi.org/https://doi.org/10.1176/appi.books.9780890425787

Amri, S., & Bemak, F. (2013). Mental health help-seeking behaviors of Muslim immigrants in the United States: Overcoming social stigma and cultural mistrust. *Journal of Muslim Mental Health*, *7*(1), 43–63. https://doi.org/10.3998/jmmh.10381607.0007.104

Ata, A. W. (2016). Mental health of bereaved Muslims in Australia: religious, gender, after death communication (adc) and grief issues. *Journal of Religious Education*, *64*(1), 47–58. https://doi.org/10.1007/s40839-016-0028-y

Azhar, S. (2020). Islamic Processes for Managing Grief, Loss and Death. *Working with Grief and Traumatic Loss: Theory, Practice, Personal Reflection, and Self-Care*, *January 2020*, 188–197.

Azuma, H. (2007). *International Journal of Psychology in a Non-Western Country* (Issue February 2013, pp. 37–41).

Badrī, M. (1979). *The dilemma of Muslim psychologists*. MWH Publishers.

Barlow, D. H., Nock, M., & Hersen, M. (2009). *Single case experimental designs: Strategies for studying behavior change* (3rd ed.). Boston, MA: Allyn & Bacon

Beckett, C., & Dykeman, C. (2017). A Metatheory of Grief: implications for Counselors. *Ideas and Research You Can Use*, *30*, 1–15.

Betriana, F., & Kongsuwan, W. (2019). Lived experiences of grief of Muslim nurses caring for patients who died in an intensive care unit: A phenomenological study. *Intensive and Critical Care Nursing*, *52*, 9–16. https://doi.org/10.1016/j.iccn.2018.09.003

Boelen, P. A. (2021). Symptoms of prolonged grief disorder as per DSM-5-TR, posttraumatic stress, and depression: Latent classes and correlations with anxious and depressive avoidance. *Psychiatry Research*, *302*(March), 114033. https://doi.org/10.1016/j.psychres.2021.114033

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of Complicated Grief: A Comparison Between Cognitive-Behavioral Therapy and Supportive Counseling. *Journal of Consulting and Clinical Psychology*, *75*(2), 277–284. https://doi.org/10.1037/0022-006X.75.2.277

Boelen, P. A., & Lenferink, L. I. M. (2022). Prolonged grief disorder in DSM-5-TR: Early predictors and longitudinal measurement invariance. *Australian and New Zealand Journal of Psychiatry*, *56*(6), 667–674. https://doi.org/10.1177/00048674211025728

Boelen, P. A., & Lensvelt-Mulders, G. J. L. M. (2005). Psychometric properties of the Grief Cognitions Questionnaire (GCQ). *Journal of Psychopathology and Behavioral Assessment*, *27*(4), 291–303. https://doi.org/10.1007/s10862-005-2409-5

Boelen, P. A., & Prigerson, H. G. (2007). The influence of symptoms of prolonged grief disorder, depression, and anxiety on quality of life among bereaved adults: A prospective study. *European Archives of Psychiatry and Clinical Neuroscience*, *257*(8), 444–452. https://doi.org/10.1007/s00406-007-0744-0

Boelen, P. A., Reijntjes, A., & Smid, G. E. (2015). Concurrent and prospective associations of intolerance of uncertainty with symptoms of prolonged grief, posttraumatic stress, and depression after bereavement. *Journal of Anxiety Disorders*, *41*, 65–72. https://doi.org/10.1016/j.janxdis.2016.03.004

Boelen, P. A., & Smid, G. E. (2017). Disturbed grief: Prolonged grief disorder and persistent complex bereavement disorder. *BMJ (Online)*, *357*(May), 0–11. https://doi.org/10.1136/bmj.j2016

Boelen, P. A., Stroebe, M. S., Schut, H. A. W., & Zijerveld, A. M. (2006). *Continuing bonds and grief: a prospective analysis*. 767–776. https://doi.org/10.1080/07481180600852936

Boelen, P. A., van den Hout, M. A., & van den Bout, J. (2006). A cognitive-behavioral conceptualization of complicated grief. *Clinical Psychology: Science and Practice*, *13*(2), 109–128. https://doi.org/10.1111/j.1468-2850.2006.00013.x

Bonanno, G. A., & Kaltman, S. (2001). The Varieties of grief experince. *Clinical Psychology Review*, *21*(5), 705–734.

Bonanno, G. A., Lehman, D. R., Tweed, R. G., Haring, M., Wortman, C. B., Sonnega, J., Carr, D., & Nesse, R. M. (2002). Resilience to loss and chronic grief: A prospective study from preloss to 18-months postloss. *Journal of Personality and Social Psychology*, *83*(5), 1150–1164. https://doi.org/10.1037/0022-3514.83.5.1150

Bowlby, J. (1961). Processes of Mourning.pdf. *International Journal of Psycho-Analysis*, *42*, 317-340.

Bowlby, J. (1963). Pathological Mourning and Childhood Mourning. *The Psychoanalytic Study of the Child*, *18*, 9–52.

Bowlby, J. (1980). *Attachment and loss: Loss, sadness and depression* (Vol. 3). Basic. https://doi.org/10.1007/BF02049873

Bryant, R. A. (2013). Is pathological grief lasting more than 12 months grief or depression? *Current Opinion in Psychiatry*, *26*(1), 41–46. https://doi.org/10.1097/YCO.0b013e32835b2ca2

Burke, L. A., Crunk, A. E., Neimeyer, R. A., & Bai, H. (2021). Inventory of Complicated Spiritual Grief 2.0 (ICSG 2.0): Validation of a revised measure of spiritual distress in bereavement. *Death Studies*, *45*(4), 249–265. https://doi.org/10.1080/07481187.2019.1627031

Burke, L. A., & Neimeyer, R. A. (2012). *Prospective Risk Factors for Complicated Grief: A Review of the Empirical Literature*. *January*, 1–25.

Burke, L. A., & Neimeyer, R. A. (2014). Complicated Spiritual Grief I: Relation to Complicated Grief Symptomatology Following Violent Death Bereavement. *Death Studies*, *38*(4), 259–267. https://doi.org/10.1080/07481187.2013.829372

Carryer, J. R., & Greenberg, L. S. (2010). Optimal Levels of Emotional Arousal in Experiential Therapy of Depression. *Journal of Consulting and Clinical Psychology*, *78*(2), 190–199. https://doi.org/10.1037/a0018401

Čepulienė, A. A., & Skruibis, P. (2022). The Role of Spirituality during Suicide Bereavement: A Qualitative Study. *International Journal of Environmental Research and Public Health*, *19*(14). https://doi.org/10.3390/ijerph19148740

Cesur, G., & Durak-Batıgün, A. (2018). A Turkish adaptation of the grief cognitions questionnaire: Factor analysis, reliability and validity. *Current Psychology 40*(1)*,* 72-80. https://doi.org/10.1007/s12144-018-9983-7

Cesur-Soysal, G., & Durak-Batıgün, A. (2020). Prolonged grief, emotion regulation and loss-related factors: An investigation based on cognitive and behavioral conceptualization. *Death Studies*, *0*(0), 1–13. https://doi.org/10.1080/07481187.2020.1846639

Chen, Z., Ying, J., Ingles, J., Zhang, D., Rajbhandari-Thapa, J., Wang, R., Emerson, K. G., & Feng, Z. (2020). Gender differential impact of bereavement on health outcomes: evidence from the China Health and Retirement Longitudinal Study, 2011–2015. *BMC Psychiatry*, *20*(1), 1–12. https://doi.org/10.1186/s12888-020-02916-2

Clarke, K. M., & Greenberg, L. S. (1986). Differential Effects of the Gestalt Two-Chair Intervention and Problem Solving in Resolving Decisional Conflict. *Journal of Counseling Psychology*, *33*(1), 11–15. https://doi.org/10.1037/0022-0167.33.1.11

Cuijpers, P., van Straten, A., & Warmerdam, L. (2007). Behavioral activation treatments of depression: A meta-analysis. *Clinical Psychology Review*, *27*(3), 318–326. https://doi.org/10.1016/j.cpr.2006.11.001

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2006). Sense-making, grief, and the experience of violent loss: Toward a mediational model. *Death Studies*, *30*(5), 403–428. https://doi.org/10.1080/07481180600614351

Daldrup, R. J., Beutler, L. E., Greenberg, L. S., & Engle, D. (1988). *Focused expressive psychotherapy: A Gestalt therapy for individuals with constricted affect.* Guilford Press.

Damasio, A. R. (1994). *Descartes' error: Emotion, reason, and the human brain.* G.P. Putnam's Sons.

Davoudi, N. (2022). Remember Death: An Examination of Death, Mourning, and Death Anxiety Within Islam. *Open Theology*, *8*(1), 221–236. https://doi.org/10.1515/opth-2022-0205

De Stefano, R., Muscatello, M. R. A., Bruno, A., Cedro, C., Mento, C., Zoccali, R. A., & Pandolfo, G. (2020). Complicated grief: A systematic review of the last 20 years. *International Journal of Social Psychiatry*, 1–8. https://doi.org/10.1177/0020764020960202

Dell'Osso, L., Carmassi, C., Musetti, L., Socci, C., Shear, M. K., Conversano, C., Maremmani, I., & Perugi, G. (2012). Lifetime mood symptoms and adult separation anxiety in patients with complicated grief and/or post-traumatic stress disorder: A preliminary report. *Psychiatry Research*, *198*(3), 436–440. https://doi.org/10.1016/j.psychres.2011.12.020

Djelantik, A. A. A. M. J., Robinaugh, D. J., & Boelen, P. A. (2022). The course of symptoms in the first 27 months following bereavement: A latent trajectory

analysis of prolonged grief, posttraumatic stress, and depression. Psychiatry Research, 311(March), 114472. https://doi.org/10.1016/j.psychres.2022.114472

Downe-Wamboldt, B., & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. *Death Studies*, *21*(2), 177–188. https://doi.org/10.1080/074811897202065

Druart, T.-A. (2000). Philosophical Consolation in Christianity and Islam: Boethius and al-Kindi. *Topoi*, *19*(1), 25–34.

Eisma, M. C., Boelen, P. A., van den Bout, J., Stroebe, W., Schut, H. A. W., Lancee, J., & Stroebe, M. S. (2015). Internet-Based Exposure and Behavioral Activation for Complicated Grief and Rumination: A Randomized Controlled Trial. *Behavior Therapy*, *46*(6), 729–748. https://doi.org/10.1016/j.beth.2015.05.007

Eisma, M. C., Rinck, M., Stroebe, M. S., Schut, H. A. W., Boelen, P. A., Stroebe, W., & Van Den Bout, J. (2015). Rumination and implicit avoidance following bereavement: An approach avoidance task investigation. *Journal of Behavior Therapy and Experimental Psychiatry*, *47*, 84–91. https://doi.org/10.1016/j.jbtep.2014.11.010

Eisma, M. C., Rosner, R., & Comtesse, H. (2020). ICD-11 Prolonged Grief Disorder Criteria: Turning Challenges Into Opportunities With Multiverse Analyses. *Frontiers in Psychiatry*, *11*(August), 1–5. https://doi.org/10.3389/fpsyt.2020.00752

Field, N. P., Gao, B., & Paderna, L. (2005). Continuing bonds in bereavement: An attachment theory based perspective. *Death Studies*, *29*(4), 277–299. https://doi.org/10.1080/07481180590923689

Field, N. P., & Horowitz, M. J. (1998). Applying an empty-chair monologue paradigm to examine unresolved grief. *Psychiatry*, *61*(4), 279–287. https://doi.org/10.1080/00332747.1998.11024840

Freud, S. (1917). Mourning and Melancholia. *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, *14(1914-19*, 237–258. https://doi.org/10.4324/9781315524771-17

Gillies, J., & Neimeyer, R. A. (2006). Loss, grief, and the search for significance: toward a model of meaning reconstruction in bereavement. *Journal of Constructivist Psychology*, *19*(January 2005), 31–65. https://doi.org/10.1080/10720530500311182

Goldman, R. N., & Watson, J. C. (2011). Contrasting Two Clients in Emotion-Focused Therapy for Depression 2. *Pragmatic Case Studies in Psychotherapy*, *7*(2011), 305–338. http://pcsp.libraries.rutgers.edu

Greenberg, L. S. (2010). Emotion-Focused Therapy: an Overview. *Turkish Psychological Counselling and Guidance Journal*, *4*(33), 1–12.

Greenberg, L. S. (2013). *Emotion-Focused Therapy Coaching Clients to Work Through Their Feelings* (Vol. 53, Issue 9).

Greenberg, L. S., & Foerster, F. S. (1996). Task analysis exemplified: The process of resolving unfinished business. *Journal of Consulting and Clinical Psychology*, *64*(3), 439–446. https://doi.org/10.1037//0022-006x.64.3.439

Greenberg, L. S., & Goldman, R. N. (2019). *Clinical handbook of emotion focus therapy*. American Psychological Association.

Greenberg, L. S., & Malcolm, W. (2002). Resolving unfinished business: Relating process to outcome. *Journal of Consulting and Clinical Psychology*, *70*(2), 406–416. https://doi.org/10.1037/0022-006X.70.2.406

Greenberg, L. S., Rice, L., & Elliott, R. (1993). *Facilitating Emotional Change The Moment-by-Moment Process*. The Guilford Press.

Groff, P. S. (2004). Al-Kindi and Nietzsche on the Stoic Art of Banishing Sorrow. *The Journal of Nietzsche Studies*, *28*(1), 139–173. https://doi.org/10.1353/nie.2004.0013

Gross, J. J. (2014). *Handbook of emotion regulation* (2nd ed.). Guilford Press.

Hagl, M., Powell, S., Rosner, R., & Butollo, W. (2015). Dialogical Exposure with Traumatically Bereaved Bosnian Women: Findings from a Controlled Trial. *Clinical Psychology and Psychotherapy*, *22*(6), 604–618. https://doi.org/10.1002/cpp.1921

Hall, C. (2014). Bereavement theory: recent developments in our understanding of grief and bereavement. *Bereavement Care*, *33*(1), 7–12. https://doi.org/10.1080/02682621.2014.902610

Hamarneh, S. (1965). Al-kindī, a ninth-century physician, philosopher, and scholar. *Medical History*, *9*(4), 328–342. https://doi.org/10.1017/S0025727300030982

Hammad, A. Z. (2009). *The Gracious Quran a Modern-Phrased Interpretation in English*. Lucent Interpretations.

Hansen, K. L., Nielsen, S. L., Erekson, D. M., Fischer, L., Pedersen, T. R., & Smith, T. B. (2023). Effects of religious and spiritual struggles on psychotherapy process and outcome. *Spirituality in Clinical Practice*, *12*(1), 124–135. https://doi.org/10.1037/scp0000343

Haque, A. (1998). Psychology and Religion: Their Relationship and Integration from an Islamic Perspective. *American Journal of Islam and Society*, *15*(4), 97–116. https://doi.org/10.35632/ajis.v41i1.3425

Haque, A. (2004). *Psychology from Islamic Perspective*.

Haque, A., Ellyn, G., Ellyn, G., & Rothman, A. E. (2016). Integrating Islamic Traditions in Modern Psychology: Research Trends in Last Ten Years. *Journal of Muslim Mental Health*, *10*(1).

Hedayat, K. (2006). When the spirit leaves: Childhood death, grieving, and bereavement in Islam. *Journal of Palliative Medicine*, *9*(6), 1282–1291. https://doi.org/10.1089/jpm.2006.9.1282

Holland, J. M., Klingspon, K. L., Lichtenthal, W. G., & Neimeyer, R. A. (2020). The Unfinished Business in Bereavement Scale (UBBS): Development and psychometric evaluation. *Death Studies*, *44*(2), 65–77. https://doi.org/10.1080/07481187.2018.1521101

Holland, J. M., & Neimeyer, R. (2010). An examination of stage theory of grief among individuals bereaved by natural and violent causes: A meaning-oriented contribution. *Omega: Journal of Death and Dying*, *61*(2), 103–120. https://doi.org/10.2190/OM.61.2.b

Holland, J. M., Plant, C. P., Klingspon, K. L., & Neimeyer, R. A. (2020). Bereavement-related regrets and unfinished business with the deceased. *Death Studies*, *44*(1), 42–47. https://doi.org/10.1080/07481187.2018.1521106

Holland, J. M., Thompson, K. L., Rozalski, V., & Lichtenthal, W. G. (2014). Bereavement-related regret trajectories among widowed older adults. *Journals of Gerontology - Series B Psychological Sciences and Social Sciences*, *69*(1), 40–47. https://doi.org/10.1093/geronb/gbt050

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research*, *11*(2), 213–218. https://doi.org/10.1016/0022-3999(67)90010-4

Honoré, F., Lestienne, L., Vieux, M., Bislimi, K., Chalancon, B., & Leaune, E. (2025). "A sign that I am not alone": A grounded theory-informed qualitative study on spirituality after suicide bereavement. *Death Studies*, *49*(6), 766–777. https://doi.org/10.1080/07481187.2024.2355250

İbn Sînâ. (1959). *Ölüm Korkusundan Kurtuluş Risalesi / Namaz Risalesi (M. Hazmi Tura, Çev.)*. Orhan Mete ve Koll. Şrk. Matbaası.

Iglewicz, A., Shear, M. K., Reynolds, C. F., Simon, N., Lebowitz, B., & Zisook, S. (2020). Complicated grief therapy for clinicians: An evidence-based protocol for mental health practice. *Depression and Anxiety*, *37*(1), 90–98. https://doi.org/10.1002/da.22965

Inayat, Q. (2007). Islamophobia and the therapeutic dialogue: Some reflections. *Counselling Psychology Quarterly*, *20*(3), 287–293. https://doi.org/10.1080/09515070701567804

Işıklı, S., Keser, E., Prigerson, H. G., & Maciejewski, P. K. (2020). Validation of the prolonged grief scale (PG-13) and investigation of the prevalence and risk factors of prolonged grief disorder in Turkish bereaved samples. *Death Studies*, *46*(3), 628–638. https://doi.org/10.1080/07481187.2020.1745955

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12–19. https://doi.org/10.1037/0022-006X.59.1.12

Jayyusi-Lehn, G. (2002). *The Epistle of Ya'qub ibn Ishaq al-Kindi on the Device for Dispelling Sarrow*. *29*, 121–135. https://doi.org/10.1080/135301902200001263

Josek, A. K., Schaich, A., Braakmann, D., Assmann, N., Jauch-Chara, K., Arntz, A., Schweiger, U., & Fassbinder, E. (2023). Chairwork in schema therapy for patients with borderline personality disorder—A qualitative study of patients' perceptions. *Frontiers in Psychiatry*, *14*(4). https://doi.org/10.3389/fpsyt.2023.1180839

Kaiser, J., Nagl, M., Hoffmann, R., Linde, K., & Kersting, A. (2022). Therapist-Assisted Web-Based Intervention for Prolonged Grief Disorder After Cancer Bereavement: Randomized Controlled Trial. *JMIR Mental Health*, *9*(2). https://doi.org/10.2196/27642

Kaltman, S., & Bonanno, G. A. (2003). Trauma and bereavement: Examining the impact of sudden and violent deaths. *Journal of Anxiety Disorders*, *17*(2), 131–147. https://doi.org/10.1016/S0887-6185(02)00184-6

Kazdin, A. E. (2021). Single-case experimental designs: Characteristics, changes, and challenges. *Journal of the Experimental Analysis of Behavior*, *115*(1), 56–85. https://doi.org/10.1002/jeab.638

Kellogg, S. (2004). Dialogical encounters: Contemporary perspectives on "chairwork" in psychotherapy. *Psychotherapy: Theory, Research & Practice*, *41*(3), 310–320. https://doi.org/10.1037/0033-3204.41.3.310

Kellogg, S. (2015). *Transformational Chairwork*. ROWMAN & LITTLEFIELD.

Kellogg, S., Trapp, R., & Rizzon, A. (2023). Bringing It to Life: Using Chairwork and the Four Dialogues in Schema Therapy. *New York City Cognitive Therapy Association Newsletter*, 1–15.

Kersting, A., Brähler, E., Glaesmer, H., & Wagner, B. (2011). Prevalence of complicated grief in a representative population-based sample. *Journal of Affective Disorders*, *131*(1–3), 339–343. https://doi.org/10.1016/j.jad.2010.11.032

Keshavarzi, H., & Ali, B. (2020). Foundations of Traditional lslamically Integrated Psychotherapy (TIIP). In *Applying Islamic Principles to Clinical*

MentalHealth Care: Introducing Traditional Islamically Integrated Psychotherapy.

Keshavarzi, H., & Haque, A. (2013). Outlining a Psychotherapy Model for Enhancing Muslim Mental Health Within an Islamic Context. *International Journal for the Psychology of Religion*, *23*(3), 230–249. https://doi.org/10.1080/10508619.2012.712000

Keshavarzi, H., & Keshavarzi, S. (2020). Emotionally Oriented Psychotherapy. In H. Keshavarzi, F. Khan, B. Ali, & R. Awaad (Eds.), *Applying Islamic Principles to Clinical Mental Health Care* (pp. 171–208). Routledge. https://doi.org/10.4324/9781003043331-12

Keshavarzi, H., & Khan, F. (2018). Outlining a Case Illustration of Traditional Islamically Integrated Psychotherapy (TIIP). In K. Q. and M. Hynie (Ed.), *Islamically integrated psychotherapy: Uniting faith and professional practice.* (pp. 175–207). PA: Templeton Press.

Keshavarzi, H., Khan, F., Ali, B., & Awaad, R. (Eds.). (2020). *Applying Islamic principles to clinical mental health care: Introducing traditional Islamically integrated psychotherapy.* Routledge. https://www.ptonline.com/articles/how-to-get-better-mfi-results

Khan, F., Keshavarzi, H., Ahmad, M., Ashai, S., & Sanders, P. (2023). Application of Traditional Islamically Integrated Psychotherapy (TIIP) and Its Clinical Outcome on Psychological Distress Among American Muslims in Outpatient Therapy. *Spirituality in Clinical Practice*, *November 3*. https://doi.org/10.1037/scp0000350

Khosravi, M., & Kasaeiya, R. (2023). A Current Challenge in Classi fi cation and Treatment of DSM-5-TR Prolonged Grief Disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, *15*(4), 567–568. https://doi.org/https://dx.doi.org/10.1037/tra0001510

Kindî. (2015). *Felsefî risâleler: Metin, çeviri (Trans, M. Kaya).* Türkiye Yazma Eserler Kurumu Başkanlığı.

Klass, D., Silverman, P. R., & Nickman, S. (2014). C*ontinuing bonds: New understandings of grief.* Taylor & Francis.

King, M., Vasanthan, M., Petersen, I., Jones, L., Marston, L., & Nazareth, I. (2013). Mortality and Medical Care after Bereavement: A General Practice Cohort Study. *PLoS ONE*, *8*(1), 1–8. https://doi.org/10.1371/journal.pone.0052561

Klingspon, K. L., Holland, J. M., Neimeyer, R. A., & Lichtentha, W. G. (2015). Unfinished Business in Bereavement. *Physiology & Behavior*, *39*(7), 387=398. https://doi.org/10.1080/07481187.2015.1029143.Unfinished

Knowles, L. M., Jovel, K. S., Mayer, C. M., Bottrill, K. C., Kaszniak, A. W., Sbarra, D. A., Lawrence, E. E., & O'Connor, M.-F. (2021). A controlled trial of two

mind–body interventions for grief in widows and widowers. *Journal of Consulting and Clinical Psychology*, *89*(7), 640–654. https://doi.org/10.1037/ccp0000653

Koç, V., & Kafa, G. (2019). Cross-Cultural Research on Psychotherapy: The Need for a Change. *Journal of Cross-Cultural Psychology*, *50*(1), 100–115. https://doi.org/10.1177/0022022118806577

Konkan, R., Şenormancı, Ö., Güçlü, O., Aydın, E., & Sungur, M. Z. (2013). Validity and reliability study for the Turkish adaptation of the Generalized Anxiety Disorder-7 (GAD-7) Scale. *Archives of Neuropsychiatry, 50*(1), 53-58. https://doi.org/10.4274/npa.y6308

Komischke-konnerup, K. B., Zachariae, R., Boelen, P. A., Marello, M. M., & Connor, M. O. (2024). Grief-Focused Cognitive Behavioral Therapies for Prolonged Grief Symptoms: A Systematic Review and Meta-Analysis. *Journal of Consulting and Clinical Psychology*, *92*(4), 236–248. https://doi.org/10.1037/ccp0000884.supp

Kristiansen, M., & Sheikh, A. (2012). Understanding faith considerations when caring for bereaved muslims. *Journal of the Royal Society of Medicine, Supplement*, *105*(12), 513–517. https://doi.org/10.1258/jrsm.2012.120284

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The Patient Health Questionnaire-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606-613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x PubMed+1

Kübler-Ross, E. (1969). *On death and dying*. The Macmillan Company.

Lampropoulos, G. K., & Nicholas, D. R. (2001). An expressive-cognitive approach to the resolution of unfinished business. *Journal of Mental Health Counseling*, *23*(4), 328–341.

Lane, R. D., Ryan, L., Nadel, L., & Greenberg, L. (2015). Memory reconsolidation, emotional arousal, and the process of change in psychotherapy: New insights from brain science. *Behavioral and Brain Sciences*, *38*, 1–64. https://doi.org/10.1017/S0140525X14000041

Lee, E., & Tratner, M. (2021). Make every session count for clients! Rethinking clinical social work practice from Single Session Therapy (SST): A case illustration of Emotion-Focused Therapy (EFT). *Journal of Social Work Practice*, *35*(4), 447–467. https://doi.org/10.1080/02650533.2020.1835846

Lenferink, L. I. M., Eisma, M. C., Buiter, M. Y., de Keijser, J., & Boelen, P. A. (2023). Online cognitive behavioral therapy for prolonged grief after traumatic loss: a randomized waitlist-controlled trial. *Cognitive Behaviour Therapy*, *00*(00), 1–15. https://doi.org/10.1080/16506073.2023.2225744

Lenferink, L. I. M., Franzen, M., ten Klooster, P. M., Knaevelsrud, C., Boelen, P. A., & Heeke, C. (2023). The Traumatic Grief Inventory-Clinician Administered: A psychometric evaluation of a new interview for ICD-11 and DSM-5-TR prolonged grief disorder severity and probable caseness. *Journal of Affective Disorders*, *330*(March), 188–197. https://doi.org/10.1016/j.jad.2023.03.006

Li, J., Chow, A. Y. M., Shi, Z., & Chan, C. L. W. (2015). Prevalence and risk factors of complicated grief among Sichuan earthquake survivors. *Journal of Affective Disorders*, *175*, 218–223. https://doi.org/10.1016/j.jad.2015.01.003

Lindemann, E. (1944). *Symptomatology and management of acute grief. American Journal of Psychiatry*, 101, 141-148.

Lundorff, M., Holmgren, H., Zachariae, R., Farver-Vestergaard, I., & O'Connor, M. (2017). Prevalence of prolonged grief disorder in adult bereavement: A systematic review and meta-analysis. *Journal of Affective Disorders*, *212*(January), 138–149. https://doi.org/10.1016/j.jad.2017.01.030

Maccallum, F., & Bryant, R. A. (2013). A Cognitive Attachment Model of prolonged grief: Integrating attachments, memory, and identity. *Clinical Psychology Review*, *33*(6), 713–727. https://doi.org/10.1016/j.cpr.2013.05.001

Maccallum, F., Galatzer-Levy, I. R., & Bonanno, G. A. (2015). Trajectories of depression following spousal and child bereavement: A comparison of the heterogeneity in outcomes. *Journal of Psychiatric Research*, *69*, 72–79. https://doi.org/10.1016/j.jpsychires.2015.07.017

Maciejewski, P. K., Maercker, A., Boelen, P. A., & Prigerson, H. G. (2016). "Prolonged grief disorder" and "persistent complex bereavement disorder", but not "complicated grief", are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. *World Psychiatry*, *15*(3), 266–275. https://doi.org/10.1002/wps.20348

Maercker, A., Brewin, C. R., Bryant, R. A., Cloitre, M., Van Ommeren, M., Jones, L. M., Humayan, A., Kagee, A., Llosa, A. E., Rousseau, C., Somasundaram, D. J., Souza, R., Suzuki, Y., Weissbecker, I., Wessely, S. C., First, M. B., & Reed, G. M. (2013). Diagnosis and classification of disorders specifically associated with stress: Proposals for ICD-11. *World Psychiatry*, *12*(3), 198–206. https://doi.org/10.1002/wps.20057

Marris, P. (1958). *Widows and their families.* London: Routledge & Kegan Paul.

Melhem, N. M., Porta, G., Payne, M. W., & Brent, D. A. (2013). Identifying prolonged grief reactions in children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(6), 599–607. https://doi.org/10.1016/j.jaac.2013.02.015.Identifying

Mitha, K. (2020). Conceptualising and addressing mental disorders amongst Muslim communities: Approaches from the Islamic Golden Age. *Transcultural Psychiatry*, *57*(6), 763–774. https://doi.org/10.1177/1363461520962603

Mohaghegh, M. (1967). Notes on the “Spiritual Physic” of Al-Razi. *Studia Islamica*, *26*(26), 5. https://doi.org/10.2307/1595230

Muntigl, P., Chubak, L., & Angus, L. (2017). Entering chair work in psychotherapy : An interactional structure for getting emotion-focused talk underway. *Journal of Pragmatics*, *117*, 168–189. https://doi.org/10.1016/j.pragma.2017.06.016

Neimeyer, R. A. (2000). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies*, *24*(6), 541–558. https://doi.org/10.1080/07481180050121480

Nielsen, M. K., Neergaard, M. A., Jensen, A. B., Vedsted, P., Bro, F., & Guldin, M. B. (2017). Predictors of Complicated Grief and Depression in Bereaved Caregivers: A Nationwide Prospective Cohort Study. *Journal of Pain and Symptom Management*, *53*(3), 540–550. https://doi.org/10.1016/j.jpainsymman.2016.09.013

O’Leary, E., & Nieuwstraten, I. M. (1999). Unfinished business in gestalt reminiscence therapy: A discourse analytic study. *Counselling Psychology Quarterly*, *12*(4), 395–411. https://doi.org/10.1080/09515079908254108

Ociskova, M., Prasko, J., Gecaitė-Stonciene, J., Abeltina, M., Kotian, M., Slepecky, M., Hodny, F., Vanek, J., Krone, I., Zatkova, M., Sollar, T., Burkauskas, J., & Juskiene, A. (2022). Chairwork in cognitive behavioral therapy and schema therapy: Options in practice. *Activitas Nervosa Superior Rediviva*, *64*(4), 124–141.

Özcan, G. (2023). *Erken İslam geleneğinde dört duygu: Hüzün, ölüm kaygısı, mutluluk, korku. Terapi merkezli bir bakış*. Kaknüs Yayınları.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving "Unfinished Business ": Efficacy of Experiential Therapy Using Empty-Chair Dialogue. *Journal of Consulting and Clinical Psychology*, *63*(3), 419–425.

Pajević, A., Pajević, I., Dedić, E., & Hasanović, M. (2021). A Treatise of the Islamic Philosopher Ibn Sina (Avicenna) on the Fear of Death and the Treatment of Anxiety Caused by It. *Psychiatria Danubina*, *33*, 889–894.

Papa, A., Lancaster, N. G., & Kahler, J. (2014). Commonalities in grief responding across bereavement and non-bereavement losses. *Journal of Affective Disorders*, *161*, 136–143. https://doi.org/10.1016/j.jad.2014.03.018

Papa, A., Sewell, M. T., Garrison-Diehn, C., & Rummel, C. (2013). A randomized open trial assessing the feasibility of behavioral activation for pathological grief responding. *Behavior Therapy*, *44*(4), 639–650. https://doi.org/10.1016/j.beth.2013.04.009

Parker, R. I., Vannest, K. J., & Davis, J. L. (2011). Effect size in single-case research: A review of nine nonoverlap techniques. *Behavior Modification*, *35*(4), 303–322. https://doi.org/10.1177/0145445511399147

Parkes, C. M. (1971). Psycho-social transitions: A field for study. *Social Science & Medicine*, 5(2), 101-115.

Pascual-Leone, A., & Baher, T. (2023). Chairwork in Individual Psychotherapy: Meta-Analyses of Intervention Effects. *Psychotherapy*, *60*(3), 370–382. https://doi.org/10.1037/pst0000490

Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional Processing in Experiential Therapy: Why "the Only Way Out Is Through." *Journal of Consulting and Clinical Psychology*, *75*(6), 875–887. https://doi.org/10.1037/0022-006X.75.6.875

Peinado, V., Valiente, C., Contreras, A., Trucharte, A., Butter, S., Murphy, J., & Shevlin, M. (2024). ICD-11 prolonged grief disorder: Prevalence, predictors, and co-occurrence in a large representative sample. *International Journal of Psychology*, *59*(1), 86–95. https://doi.org/10.1002/ijop.12951

Perls, F. S. (1972). Gestalt therapy verbatim. In *Bantam Book*. https://doi.org/10.5325/gestaltreview.21.2.0167

Perls, F. S., Hefferline, R. E., & Goodman, P. (1951). Gestalt Therapy: Excitement and Growth in the Human Personality. In *Philosophy and Phenomenological Research*. The Gestalt Journal Press. https://doi.org/10.2307/2106229

Pos, A. E., Paolone, D. A., Smith, C. E., & Warwar, S. H. (2017). How does client expressed emotional arousal relate to outcome in experiential therapy for depression? *Person-Centered and Experiential Psychotherapies*, *16*(2), 173–190. https://doi.org/10.1080/14779757.2017.1323666

Poursalehi, P., Dolatian, M., Shams, J., Nasiri, M., & Mahmoodi, Z. (2020). The Path Analysis between Spiritual Well-Being and Religiosity Mediated by Mental Health and Grief Severity Fetal or Neonatal Deaths. *International Journal of Pediatrics-Mashhad*, *8*(12), 12591–12601. https://doi.org/10.22038/IJP.2020.51455.4090

Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds, C. F., Shear, M. K., Newsom, J. T., & Jacobs, S. (1995). Complicated grief as a disorder distinct from bereavement-related depression and anxiety: A replication study. *American Journal of Psychiatry*, *152*(1), 22–30. https://doi.org/10.1176/ajp.153.11.1484

Prigerson, H. G., Boelen, P. A., Xu, J., Smith, K. V., & Maciejewski, P. K. (2021). Validation of the new DSM-5-TR criteria for prolonged grief disorder and the PG-13-Revised (PG-13-R) scale. *World Psychiatry*, *20*(1), 96–106. https://doi.org/10.1002/wps.20823

Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., & Maciejewski, P. K. (2009). Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for DSM-V and ICD-11. *PLoS Medicine*. https://doi.org/10.1371/journal.pmed.1000121

Prigerson, H. G., & Jacobs, S. C. (1997). Traumatic grief as a distinct disorder: A rationale, consensus criteria, and a preliminary empirical test. *American Journal of Psychiatry*, *May*, 616–623. https://doi.org/10.1037/10436-026

Prigerson, H. G., Kakarala, S., Gang, J., & Maciejewski, P. K. (2021). History and Status of Prolonged Grief Disorder as a Psychiatric Diagnosis. *Annual Review of Clinical Psychology*, *17*(1). https://doi.org/10.1146/annurev-clinpsy-081219-093600

Pugh, M. (2017). Chairwork in cognitive behavioural therapy: A narrative review. *Cognitive Therapy and Research*, *41*, 16–30.

Pugh, M. (2018). Cognitive behavioural chairwork. *International Journal of Cognitive Therapy*, *11*, 100–116.

Pustejovsky, J. E., Hedges, L. V, & Shadish, W. R. (2014). Design-comparable effect sizes in Multiple Baseline Designs: A General Modeling Framework. *Journal of Educational and Behavioral Statistics*, *39*(5), 368–393.

R Core Team. (2025). *R: A language and environment for statistical computing* (Version 4.5.1). R Foundation for Statistical Computing. https://www.R-project.org/

Raduan, N. J. N., Rosly, N. H. M., Razali, Z. A., Al Siddiq, M., & Salleh, M. R. (2016). Grief & personal growth: Reflection from Quran, Hadith and modern medicine. *International Medical Journal Malaysia*, *17*(Specialissue2), 243–248. https://doi.org/10.31436/imjm.v17i2.957

Rafaeli, E., Maurer, O., & Thoma, N. C. (2015). Working with modes in schema therapy. *Working with Emotion in Cognitive-Behavioral Therapy: Techniques for Clinical Practice*, *October 2014*, 263–287.

Rassool, G. H. (2015). Cultural Competence in Counseling the Muslim Patient: Implications for Mental Health. *Archives of Psychiatric Nursing*, *29*(5), 321–325. https://doi.org/10.1016/j.apnu.2015.05.009

Rāzī, A. B. M. ibn Z., & Arberry, A. J. (1950). The spiritual physick of Rhazes. In *The Wisdom of the East series*. Butler & Tanner Ltd.

Rees, W. D., & Lutkins, S. G. (1967). Mortality of Bereavement. *British Medical Journal*, *4*(5570), 13–16. https://doi.org/10.1136/bmj.4.5572.176-a

Reik, T. (1948). Listening with the Third Ear. New York: Farrar, Straus.

Reitsma, L., Boelen, P. A., de Keijser, J., & Lenferink, L. I. M. (2021). Online treatment of persistent complex bereavement disorder, posttraumatic stress disorder, and depression symptoms in people who lost loved ones during the COVID-19 pandemic: study protocol for a randomized controlled trial and a controlled trial. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2021.1987687

Reitsma, L., Boelen, P. A., de Keijser, J., & Lenferink, L. I. M. (2023). Self-guided online treatment of disturbed grief, posttraumatic stress, and depression in adults bereaved during the COVID-19 pandemic: A randomized controlled trial. *Behaviour Research and Therapy*, *163*(March), 104286. https://doi.org/10.1016/j.brat.2023.104286

Reitsma, L., Killikelly, C., Müller, H., Larsen, L., Boelen, P., & Lenferink, L. I. M. (2023). Prevalence and correlates of positive and negative psychological effects of bereavement due to COVID-19: A living systematic review. *F1000Research*, *12*(March). https://doi.org/10.12688/f1000research.130397.1

Reynolds, C. F., Prigerson, H. G., & Shear, M. K. (2023). Special Report: Prolonged Grief Disorder - What you need to know? *Psychiatric News*, *58*(12).

Richards, P. S., Sanders, P. W., Lea, T., McBride, J. A., & Allen, G. E. K. (2015). Bringing spiritually oriented psychotherapies into the health care mainstream: A call for worldwide collaboration. *Spirituality in Clinical Practice*, *2*(3), 169–179. https://doi.org/10.1037/scp0000082

Rosner, R., Pfoh, G., & Kotoučová, M. (2011a). Treatment of complicated grief. *European Journal of Psychotraumatology*, *2*(1), 7995. https://doi.org/10.3402/ejpt.v2i0.7995

Rosner, R., Pfoh, G., & Kotoučová, M. (2011b). Treatment of complicated grief. *European Journal of Psychotraumatology*, *2*(1). https://doi.org/10.3402/ejpt.v2i0.7995

Rosner, R., Rimane, E., Vogel, A., Rau, J., & Hagl, M. (2018a). Treating prolonged grief disorder with prolonged grief-specific cognitive behavioral therapy: study protocol for a randomized controlled trial. *Trials*, *19*(241), 1–12.

Rosner, R., Rimane, E., Vogel, A., Rau, J., & Hagl, M. (2018b). Treating prolonged grief disorder with prolonged grief-specific cognitive behavioral therapy: Study protocol for a randomized controlled trial. *Trials*, *19*(1), 1–13. https://doi.org/10.1186/s13063-018-2618-3

Rothaupt, J. W., & Becker, K. (2007). A Literature Review of Western Bereavement Theory: From Decathecting to Continuing Bonds. *The Family Journal*, *15*(1), 6–15. https://doi.org/10.1177/1066480706294031

Rubin, S. S., Malkinson, R., & Witztum, E. (2020). Traumatic Bereavements: Rebalancing the Relationship to the Deceased and the Death Story Using the Two-Track Model of Bereavement. *Frontiers in Psychiatry*, *11*(September), 1–12. https://doi.org/10.3389/fpsyt.2020.537596

Sauber, S., L'Abate, L., Weeks, G., & Buchanan, W. (2014). Therapeutic Rituals. *The Dictionary of Family Psychology and Family Therapy*, 1–24. https://doi.org/10.4135/9781483326573.n1439

Shahar, B., Carlin, E. R., Engle, D. E., Hegde, J., Szepsenwol, O., & Arkowitz, H. (2012). A Pilot Investigation of Emotion-Focused Two-Chair Dialogue Intervention for Self-Criticism. *Clinical Psychology and Psychotherapy*, *19*(6), 496–507. https://doi.org/10.1002/cpp.762

Shear, K., Monk, T., Houck, P., Melhem, N., Frank, E., Reynolds, C. F., & Sillowash, R. (2007). An attachment-based model of complicated grief including the role of avoidance. *European Archives of Psychiatry and Clinical Neuroscience*, *257*(8), 453–461. https://doi.org/10.1007/s00406-007-0745-z

Shear, M. K., Reynolds, C. F., Simon, N. M., Zisook, S., Wang, Y., Mauro, C., ... & Skritskaya, N. (2016). Optimizing treatment of complicated grief: A randomized clinical trial. *JAMA psychiatry*, *73*(7), 685-694.

Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., Reynolds, C. F., Lebowitz, B., Sung, S., Ghesquiere, A., Gorscak, B., Clayton, P., Ito, M., Nakajima, S., Konishi, T., Melhem, N., Meert, K., Schiff, M., O'Connor, M. F., … Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, *28*(2), 103–117. https://doi.org/10.1002/da.20780

Silverman, G. K., Jacobs, S. C., Kasl, S. V., Shear, M. K., Maciejewski, P. K., Noaghiul, F. S., & Prigerson, H. G. (2000). Quality of life impairments associated with diagnostic criteria for traumatic grief. *Psychological Medicine*, *30*(4), 857–862. https://doi.org/10.1017/S0033291799002524

Simon, N. M., Shear, K. M., Thompson, E. H., Zalta, A. K., Perlman, C., Reynolds, C. F., Frank, E., Melhem, N. M., & Silowash, R. (2007). The prevalence and correlates of psychiatric comorbidity in individuals with complicated grief. *Comprehensive Psychiatry*, *48*(5), 395–399. https://doi.org/10.1016/j.comppsych.2007.05.002

Spencer-Laitt, D., Curreri, A. J., Jaso, B. A., Cardona, N. D., Eustis, E. H., Barlow, D. H., & Farchione, T. J. (2024). Is Prolonged Grief Disorder an Emotional Disorder? *Journal of Loss and Trauma*, *29*(2), 117–137. https://doi.org/10.1080/15325024.2023.2236931

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. A*rchives of Internal Medicine*, 166(10), 1092-1097. https://doi.org/10.1001/archinte.166.10.1092

Spuij, M., Van Londen-Huiberts, A., & Boelen, P. A. (2013). Cognitive-Behavioral Therapy for Prolonged Grief in Children: Feasibility and Multiple Baseline Study. *Cognitive and Behavioral Practice*, *20*(3), 349–361. https://doi.org/10.1016/j.cbpra.2012.08.002

Stanford Encyclopedia of Philosophy. (2023). *al-Kindi*. 1–13.

Stiegler, J. R. (2018). *Processing emotions in emotion- focused therapy - Exploring the impact of the two-chair dialogue intervention.*

Stiegler, J. R., Molde, H., & Schanche, E. (2018). Does an emotion-focused two-chair dialogue add to the therapeutic effect of the empathic attunement to affect? *Clinical Psychology and Psychotherapy*, *25*(1), e86–e95. https://doi.org/10.1002/cpp.2144

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, *23*(3), 197–224. https://doi.org/10.1080/074811899201046

Superdock, A. K., Trejo, M., Yang, Y., Torres, C., Blazin, L. J., Baker, J. N., Spraker-Perlman, H. L., & Kaye, E. C. (2025). "Understanding why she had to leave me": The roles of religion and spirituality in narratives of parents grieving the loss of a child to cancer. *Death Studies*, *49*(5), 621–632. https://doi.org/10.1080/07481187.2024.2348059

Sutherland, O., Peräkylä, A., & Elliott, R. (2014). Conversation analysis of the two-chair self-soothing task in emotion-focused therapy. *Psychotherapy Research*, *24*(6), 738–751.

Swisher, A. K. (2010). Practice-based evidence. *Cardiopulmonary Physical Therapy Journal*, *21*(2), 4. https://doi.org/10.1016/B978-0-443-07375-5.50019-X

Syed, F. (2023). *Using Emotion-Focused Therapy Chair Work in Working with Shame and Self-Criticism in a Muslim Demographic*.

Syed, F., Keshavarzi, S., Sholapur, N., & Keshavarzi, H. (2020). A survey of islamic clergy & community leaders regarding muslim mental health first responder training. *Journal of Muslim Mental Health*, *14*(2), 1–14. https://doi.org/10.3998/JMMH.10381607.0014.201

Szuhany, K. L., Malgaroli, M., Miron, C. D., & Simon, N. M. (2020). Prolonged Grief Disorder: Course, Diagnosis, Assessment, and Treatment. *Psychiatric News*, *55*(21), 161–172. https://doi.org/10.1176/appi.pn.2020.11a12

Szuhany, K. L., Young, A., Mauro, C., Garcia de la Garza, A., Spandorfer, J., Lubin, R., Skritskaya, N. A., Hoeppner, S. S., Li, M., Pace-Schott, E., Zisook, S., Reynolds, C. F., Shear, M. K., & Simon, N. M. (2020). Impact of sleep on complicated grief severity and outcomes. *Depression and Anxiety*, *37*(1), 73–80. https://doi.org/10.1002/da.22929

Tamanaha, A. J. (2005). *CONCEPTUALIZING AMBIVALENCE AS UNFINISHED BUSINESS IN COMPLICATED BEREAVEMENT*.

Terzioğlu, A. (1999). İbn Sina. In *Türkiye Diyanet Vakfı İslâm Ansiklopedisi* (pp. 331–336). TDV İslâm Araştırmaları Merkezi.

Tobin, S. A. (1971). Saying goodbye in Gestalt therapy. *Psychotherapy: Theory, Research & Practice*, *8*(2), 150–155. https://doi.org/10.1037/h0086643

Tompkins, K. A., & Swift, J. K. (2015). Psychotherapy process and outcome research. *The encyclopedia of clinical psychology*, 1-7.

Treml, J., Linde, K., Brähler, E., & Kersting, A. (2024). Prolonged grief disorder in ICD-11 and DSM-5-TR: differences in prevalence and diagnostic criteria. *Frontiers in Psychiatry*, *15*(February), 1–9. https://doi.org/10.3389/fpsyt.2024.1266132

Vedder, A., Boerner, K., Stokes, J. E., Schut, H. A. W., Boelen, P. A., & Stroebe, M. S. (2022). A systematic review of loneliness in bereavement: Current research and future directions. *Current Opinion in Psychology*, *43*, 48–64. https://doi.org/10.1016/j.copsyc.2021.06.003

Wagner, B., Knaevelsrud, C., & Maercker, A. (2006). Internet-based cognitive-behavioral therapy for complicated grief: A randomized controlled trial. *Death Studies*, *30*(5), 429–453. https://doi.org/10.1080/07481180600614385

Warwar, S., & Greenberg., L. S. (1999). Emotional processing and therapeutic change. In *annual meeting of the International Society for Psychotherapy Research*.

Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2011). Contrasting Two Clients in Emotion-Focused Therapy for Depression 1: The Case of "Tom," "Trapped in the Tunnel." *Pragmatic Case Studies in Psychotherapy*, *7*(2), 268–304. https://doi.org/10.14713/pcsp.v7i2.1091

Wetherell, J. L. (2012). Complicated grief therapy as a new treatment approach. *Dialogues in Clinical Neuroscience*, *14*(2), 159–166. www.dialogues-cns.org

World Health Organization. (2019). *International classification of diseases for mortality and morbidity statistics (11th ed.) (ICD-11)*. https://icd.who.int/

Yamashita, R., Arao, H., Takao, A., & Masutani, E. (2017). *Unfinished Business in Families of Terminally Ill With Cancer Patients*. *54*(6), 1–7.

APPENDICES

APPENDIX A

ETHICS COMMITTEE PERMISSION

Evrak Tarih ve Sayısı: 29.12.2023-35013

T.C.
İBN HALDUN ÜNİVERSİTESİ
Sosyal ve Beşeri Bilimler Bilimsel Araştırma ve Yayın Etiği
Kurulu Başkanlığı

Sayı : E-71395021-050.06.04-35013 29.12.2023
Konu : Etik Kurulu Kararı - Feyzanur TAŞTEKNE KARTAL

İLGİLİMİ MAKAMA

Kurulumuza başvuran Feyzanur TAŞTEKNE KARTAL'ın, "The Application Of Islamically Integrated Chair-Work Techniques For Unfinished Business İn Patients With Prolonged Grief" isimli projesi; amaç, araştırma türü, veri toplama araçları, süreç ve işlemler, veri analizleri dikkate alınmak suretiyle 15.12.2023 tarihinde değerlendirilerek 2023/08-08 karar numarası ile etik açıdan uygun bulunmuştur.

Bilgilerinizi arz/rica ederim.

Prof. Dr. Alev ERKİLET
Başkan

APPENDIX B

STEP-BY-STEP TIIP GRIEF PROTOCOL

Table B.1. Step-by-Step TIIP Grief Protocol

Phase	Therapeutic Goals	Intervention Stages
1. Emphatic Attunement *Loss*	1st Session • Establish a therapeutic alliance by validating the patient's emotions and experiences through empathic attunement and active listening. • Provide psychoeducation about grief and orient the patient to the psychotherapy process (i.e. focus on emotions and chair-work). • Begin fostering trust and motivation to engage in therapy while instilling hope for change.	1. Uncovering and Assessing Grief • Gather a brief individual history and understand the patient's narrative of loss. • Employ active listening through usage of empathic reflections and empathic exploration. 2. Bonding & Emotional Awareness • Empathic understanding, and empathically validating the patient's feelings about their loss. • Encourage an awareness of internal emotional experiences as a foundation for further interventions and discovery. • Prizing and reinforcing a willingness to express emotions and being vulnerable in the sessions. • Creation of a feeling of safety in the therapy space
	2nd Session • Heightened emotional activation that leads to greater awareness and understanding. • Facilitate introspection about internal experiences and emotional struggles. • Highlight the importance of emotional work in understanding grief and uncovering unresolved feelings. • Begin identifying unfinished business or unprocessed emotions regarding the deceased	1. Exploring, Accessing & Expressing Emotion • Pay attention to, understand, and validate the patient's feelings about their loss. • Utilization of the empathic response strategies (empathic reflections, exploration, evocative reflections, empathic conjectures, fit questions, and emotional focusing) to heighten emotional activation and processing. • Explain the importance of emotional work and maintaining focus on emotions: *"Your emotions are like alarm signals that are attempting to draw your attention to something that's 'not right' inside."* 2. Modulating & Understanding Emotion • Empathically connect the patient's narrative with their inner emotional experience and attend to their nonverbal communication. Attune to nonverbal gestures and behaviors, and comment on your observations. • Identify and use exploratory questions to highlight emotional struggles stemming from unfinished business.

Table B.1. (cont.)

1. Emphatic Attunement *Loss*	2nd Session	3. Activate and Lean into Primary Maladaptive Emotions • Shift focus from secondary to primary maladaptive emotions (e.g., focus on the sadness underlying anxiety or anger). • Identify and activate primary maladaptive emotions to uncover unmet needs. • Pinpoint markers of unresolved emotional tensions. 4. Conclusion of Session • Set the tone for beginning chair-work for the next session
2. TIIP chair-work intervention *Missed experiences & Grief meditation*	3rd – 5th Sessions • Identify and address unresolved emotional tensions or unfinished business. • Use chair-work to help patients engage with primary maladaptive emotions (PMEs) and transform these into adaptive emotions by uncovering their underlying needs and expressing them. • Facilitate emotional activation, differentiation, and resolution to achieve psycho-spiritual equilibrium (i'tidâl) i.e. as indicated by adaptive expressions of emotions.	1. Introducing the chair-work: • Identifying markers of unfinished business and using them to transition into chair-work. • Introduce the rationale and benefits of chair-work: "It provides an opportunity to give explore unresolved or unfinished feelings and allows you to identify what you need for closure." 2. Chair-work process • Orient the patient to chair-work by guiding them to imagine the deceased in the empty chair. • Facilitate role-play where the patient alternates between expressing their feelings to the deceased and assuming the voice and perspective of the deceased when switching to the other chair. • Differentiate secondary emotions from PMEs and encourage a focus on PMEs. • Access and heighten PMEs to address unmet needs and transform maladaptive emotions into adaptive emotions that do enable the meeting of those needs. • Summarize and validate the emotional work done in each session. 3. Steps in the Resolution Process • Activate maladaptive emotions • Identify underlying needs • Empathically conjecture more adaptive expressions of emotions or ways of meeting needs • Access new emotional states • Experience or generate new emotional responses to grief • Reinforce & encourage adaptive emotion

Table B.1. (cont.)

3. Cognitive consolidation and spiritual behavioral plan *Obscurity of death*	6^{th} – 7^{th} Sessions • Help patients reflect on the insights gained during chair-work and integrate these into their cognitive and emotional frameworks. • Develop behavioral strategies informed by the patient's faith to promote continued healing. • Facilitate meaning-making regarding the loss through spiritual dimensions.	1. Integration of Emotional Insights: • Review and reflect on therapeutic progress, insights, and emotional transformations from the previous sessions. 2. Strengthening New Emotional Patterns: • Discussing and practicing new ways to respond to emotional triggers and to reinforce positive emotional experiences in their daily lives outside of the sessions. 3. Creating Alternative Adaptive Narratives • Guide the patient in creating narratives that incorporate their new emotional insights and adaptive emotional responses. 4. Behavioral Application to Everyday Life: • Assist the patient in developing a spiritual behavioral plan, which may include practices such as Quranic recitation, prayers, or charitable acts for the deceased and visiting the grave. Exploring behaviors that build growth from loss, e.g., keeping in mind the positive values, advice, or memories of the deceased to inform their presence. • Encourage contemplation on mortality and Islamic teachings about the afterlife. • Foster integration of emotional and spiritual insights into the patient's daily life to promote long-term healing and resilience.

CURRICULUM VITAE

Full Name:

Feyzanur Taştekne Kartal

Education:

2012 – 2017	BA in Psychology, İstanbul Şehir University, Türkiye
2017 – 2019	MA in Clinical Psychology, İbn Haldun University, Türkiye
2020 – 2025	Ph.D. in Clinical Psychology, İbn Haldun University, Türkiye

Work Experience:

2023 – cont.	Clinical Psychologist, Dr. Nuran Yavuz Clinic
2020 – 2025	Clinical Psychologist, Ibn Haldun University Research and Application Center (IPAM)
2023 – 2024	Lecturer, Fatih Sultan Mehmet University
2020 – 2022	Teaching Assistant in Psychology, Ibn Haldun University
2020 – 2021	Project Assistant, İstanbul Kalkınma Ajansı, Ibn Haldun University, ÖNDER and Başakşehir Belediyesi.
2019 – 2020	Project Assistant, BİHADER, Ibn Haldun University, and The Ministry of Interior
2018 – 2019	Clinical Psychologist, IPAM

Publications:

Taştekne-Kartal, F., Keshavarzi, H. (2026). A Traditional Islamically Integrated Psychotherapy (TIIP) Protocol for Unfinished Business in Patients with Prolonged Grief. *Journal of Muslim Mental Health* (in press).

Taştekne-Kartal, F. (2025, November 9). Resolving unfinished business in bereavement through chair-work: A case study of Islamically integrated therapy protocol. International Congress of Contextual Science and Psychotherapies 2025: Türkiye.

Uysal, B., Gormez, V., Karatepe, H. T., Sönmez, D., Taştekne, F., Tepedelen, M. S., & Jordan, T. R. (2023). Reducing test anxiety during the COVID-19 pandemic: A comparison of the effectiveness of cognitive behavioral therapy and acceptance and commitment therapy. *Psychological Reports*, 00332941231174394.

Payne, L. A., Ellard, K. K., Farchione, T. J., Fairholme, C. P., Barlow, D. H. (2023). Emotional Disorders A Unified Transdiagnostic Protocol in D. H. Barlow (Edi.) Clinical handbook of psychological disorders a step-by-step treatment manual (Feyzanur Taştekne, Translator.)

Uysal, B., Morgül, E., Taştekne, F., Sönmez, D., Tepedelen, M. S., Gülay, S., ... & Gormez, V. (2022). Videoconferencing-based cognitive behavioral therapy for youth with anxiety and depression during the COVID-19 pandemic. *School Psychology International*. https://doi.org/10.1177/01430343221097613.

Taştekne, F. (2022, June 13). Exploring Islamically integrated unfinished business chair-work for grief counseling—14th Annual Muslim Mental Health Conference: USA.

Taştekne, F. (2022). Narrative Terapi. Nur Başer Baykal (Edi.), in *Postmodern terapiler ve vaka uygulamaları*. İstanbul: Nobel Yayınları

Uysal, B., Yanik, M., Tastekne, F., Tuzgen, E., Altinisik, E., & Acarturk, C. (2022). Psychological problems and resilience among Syrian adolescents exposed to war. *European Journal of Trauma & Dissociation*, 6(3), 100258.

Sönmez, D., Taştekne, F., Tepedelen M.S., (2021). Hope and Mental Health During the COVID-19 Pandemic: The Role of the Big Five Personality Traits, III. International Covıd-19 and Current Issues Congress, Online, 2021, ISCYA Publishing House: Germany.

Uysal, B., Görmez, V., Eren, S., Morgül, E., Öcal, N.B., Karatepe, H.T., Sönmez, D., Taştekne, F., Tepedelen, M.S. and Yanık, M. (2021). Living with COVID-19: Depression, anxiety and life satisfaction during the new normal in Turkey. *Journal of Cognitive-Behavioral Psychotherapy and Research*. https://doi:10.5455/JCBPR.62468.