RESEARCH ON THE PSYCHOLOGY OF RELIGION, 2026, 1(1), 26-56

Research Article

Spiritual Counseling and Guidance for the Grief Process in Palliative Care

Palyatif Bakımda Yas Sürecine Yönelik Manevi Danışmanlık ve Rehberlik

Mebrure Doğan
Prof. Dr., Afyon Kocatepe University, Faculty of Theology, Department of Psychology of Religion, Afyon, Türkiye.
E-mail: mebruredogan@gmail.com
ORCID: 0000-0002-9027-144X

Abstract

Palliative care is a healthcare service that aims to enhance the quality of life of patients struggling with life-threatening illnesses and their relatives by assisting in the resolution of problems in physical, psychological, social, spiritual, and other dimensions. Spiritual care is one of the fundamental components of palliative care. The aim of this study is to examine the spiritual support needs of patients and their relatives during the grief process in palliative care and to explore how the content of spiritual counseling can be structured. This study employs the "document analysis" method, one of the qualitative research methods. The majority of patients hospitalized in palliative care units are terminal-stage patients. Therefore, both patients and their relatives experience "anticipatory grief" and enter the grief process. While coping with the burdens imposed by the illness and the intense sorrow caused by the approaching end of life, the spiritual needs of patients and their relatives increase. In order to meet these needs, it is essential to assign a spiritual care specialist in palliative care who is knowledgeable about the psychological and spiritual changes experienced during the grief process. Grief is a staged process that is expected to result in the individual's return to at least the level of equilibrium that existed prior to the loss. To meet the spiritual needs of patients and their relatives during the grieving process, spiritual counselors must first determine what these individuals' spiritual needs are and then implement a spiritual care programme focused on the grieving process, including the period after death, for the relatives of patients. In this context, based on a literature review, four categories of spiritual counselling related to the grieving process were identified in the study. These are: 'spiritual counselling to cope with the grieving process through faith, spiritual counselling to cope through religious practices, spiritual counselling to cope through values, and spiritual counselling to cope by providing religious social support.' As a result of this research, it is recommended that 'coping-based' spiritual counselling be provided to patients and their relatives in palliative care within the scope of spiritual counselling services in hospitals. The research is expected to contribute to the literature in the fields of 'palliative care' and 'hospital spiritual counselling.'

Keywords: Psychology of Religion, Spiritual Counseling and Guidance in Hospitals, Palliative Care, Grief Process, Patient, Patient's Relative.

Article History: Received: 09 Dec 2025 | Accepted: 19 Feb 2026 | Published: 30 Mar 2026

Suggested Citation
Doğan, M. (2026). Spiritual counseling and guidance for the grief process in palliative care. *Research on the Psychology of Religion, 1*(1), 26–56.

Özet

Palyatif bakım, yaşamlarını tehdit eden hastalıklarla mücadele eden hasta ve hasta yakınına fiziksel, psikolojik, sosyal, spritüel ve diğer boyutlardaki sorunlarının çözümünde yardımcı olacak, yaşam kalitesini artırmayı hedefleyen sağlık hizmetidir. Manevi bakım, palyatif bakımın bileşenlerinden biridir. Araştırmanın amacı, yas psikolojisi bağlamında palyatif bakımda hasta ve yakınlarının yas sürecindeki manevi destek ihtiyaçlarını incelemek ve manevi danışmanlığın içeriğinin nasıl oluşturulabileceğini araştırmaktır. Araştırmada nitel araştırma yöntemlerinden "doküman analizi" yöntemi kullanılmıştır. Palyatif bakımda yatan hastaların çoğunluğu terminal dönem hastalarıdır. Bu nedenle hastalar ve yakınları "beklentisel keder" yaşamakta olup yas sürecine girmektedir. Hem hastalığın sıkıntılarıyla başa çıkmak durumunda olduklarından hem de gelmekte olan son nedeniyle yoğun keder duygusu içindeyken hastalar ve yakınlarının manevi ihtiyaçları artmaktadır. Bu ihtiyaçları karşılamak üzere palyatif bakımda yas sürecinde yaşanan psikolojik, manevi değişimleri bilen bir manevi bakım uzmanının görevlendirilmesi bir gerekliliktir. Yas, bireyin en az kaybın öncesindeki denge durumuna dönmesiyle sonuçlanması beklenen ve evreleri olan bir süreçtir. Hastalar ve yakınlarının yas süreciyle ilgili manevi ihtiyaçlarının karşılanması için manevi danışmanlar tarafından öncelikle bu bireylerin manevi ihtiyaçlarının ne olduğunun belirlenmesine ve ardından hasta yakınları için vefat sonrasını da içine alan yas süreci odaklı bir manevi bakım programının uygulanmasına ihtiyaç duyulmaktadır. Bu bağlamda literatür analizine dayanarak araştırmada yas sürecine yönelik manevi danışmanlığa ilişkin dört kategori belirlenmiştir. Bunlar, "yas süreciyle inançla başa çıkmaya yönelik manevi danışmanlık, dini pratiklerle başa çıkmaya yönelik manevi danışmanlık, değerlerle başa çıkmaya yönelik manevi danışmanlık, dini sosyal destek sağlayarak başa çıkmaya yönelik manevi danışmanlık" tır. Bu araştırmanın sonucu olarak hastanelerde manevi danışmanlık hizmetleri kapsamında palyatif bakımda yatan hasta ve hasta yakınlarına yasa yönelik "başa çıkma temelli" bir manevi danışmanlık verilmesi önerilmektedir. Araştırmanın "palyatif bakım" ve "hastane manevi danışmanlığı" alanının literatürüne katkı sağlayacağı düşünülmektedir.

Anahtar Kelimeler: Din Psikolojisi, Hastanelerde Manevi Danışmanlık ve Rehberlik, Palyatif Bakım, Yas Süreci, Hasta, Hasta Yakını.

Introduction

In recent years, palliative care has gained significant importance in health services under the influence of the holistic healthcare approach. The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment, and treatment of pain and other problems, physical, psychosocial, spiritual." (World Health Organization, 2025). Palliative care, which focuses on end-of-life care for patients who no longer have hope of recovery, aims to ensure a dignified death by improving quality of life. It is emphasized that the goal of palliative care is not to add years to life, but to add life to years (Devictor & Carnevale, 2008, p. 389). Spirituality, which is included in this definition, is one of the components of palliative care. The aim of spiritual care is not to increase people's religiosity, but to help those who are trying to cope with what they experience under difficult hospital conditions to realize how spirituality can contribute to them and to assist them in finding relief (Ok et al., 2019, p. 163; Siddall et al., 2015, p. 52; Nelson-Becker, 2013, p. 112).

By its very nature, palliative care is a type of healthcare service in which long-term hospitalization is common. For this reason, patients and their relatives need not only medical treatment but also psycho-social-spiritual support. Moreover, spiritual support is a part of healthcare services in hospitals, yet its importance in palliative care is indisputable. Providing support to patients' relatives, as well as to patients themselves, is among the explicit goals of palliative care. Although providing spiritual support is included among the duties of healthcare personnel, they may remain inadequate in meeting this need fully, as they often lack the necessary professional training for such support. Therefore, within the scope of holistic healthcare services, the need to employ spiritual counselors in healthcare institutions to provide such support naturally emerges.

Patients in palliative care and their relatives have a need for spiritual counseling regarding the grief process. If the patient is conscious, he or she realizes that they are in the process of dying, and the thought that life is coming to an end plunges the individual into deep sorrow. Patients' relatives, on the other hand, while trying to cope with the difficulties arising from the burden of care, also experience the profound sadness of knowing that they will lose a family member with whom they share deep relationships and attachments and who has been a witness to their life story. Accompanying a loved one through the dying process may impose a heavy burden on them and expose them to intense stress. When the process is prolonged, patients' relatives may, in addition to the exhaustion associated with caregiving, be overwhelmed by feelings of helplessness due to the belief that there is nothing more they can do. As these individuals confront the reality of death, on the one hand they try to comfort and soothe their loved ones, while on the other hand their death anxiety is triggered, and together with existential questioning, the search for meaning comes to the fore once again.

One of the fields of inquiry in the psychology of religion is spiritual counseling and guidance. Hospital spiritual counseling is among the most widespread and active areas within the field of spiritual counseling. In Türkiye, spiritual counseling in hospitals is carried out within the framework of protocols signed between the Presidency of Religious Affairs (Diyanet İşleri Başkanlığı) and the Ministry of Health. Spiritual counselors are selected from among religious officials working under the Presidency of Religious Affairs. However, since this is a relatively new field, there is a clear need for scientific research to be conducted. For this reason, the subject of the present study has been determined as spiritual counseling for the grief process in palliative care. In this context, the aim of the study is to investigate, within the framework of grief psychology, the spiritual support needs of patients and their relatives during the grief process in palliative care and how the content of spiritual counseling can be structured. In line with this aim, the method of the study has been determined as document analysis. Document analysis, which is a qualitative method, is based on the examination or evaluation of printed and electronic (computer-based and internet-transmitted) materials. Document analysis requires the examination and interpretation of data in order to elicit meaning, gain understanding, and develop empirical knowledge (Bowen, 2009, p. 27). The aim of the document analysis in this study is to derive meaning from some quantitative and qualitative

research conducted on the subject in the literature, in line with the purpose of the study. The research questions determined within the scope of the study are as follows:

1. What is experienced during the grief process? What is the psychology of grief like?
2. What is the function of spirituality in the grief process?
3. What are the spiritual counseling needs of patients hospitalized in palliative care units and their relatives regarding the grief process?
4. How can the content of grief-focused spiritual counseling to be provided to patients and their relatives in palliative care be structured?

The Grief Process in the Terminal Stage

The term *terminal stage* is used for situations in which it is no longer possible to treat the disease or slow its progression and patients gradually enter the dying process. Patients hospitalized in palliative care units are predominantly terminal-stage patients. During this period, patients are aware that their illness has progressed and that death is approaching. For this reason, they may grieve for both the fact that they will never recover and the imminent death. The same situation applies to patients' relatives. The concept of "anticipatory grief" has been developed to describe the pre-loss state related to a loss that has not yet occurred. In this context, individuals with parents in old age, terminal-stage cancer patients and their families, as well as patients and their relatives whose illness cannot be treated and who are therefore in the terminal stage, experience this condition (Volkan-Zintl, 2019, p. 24). Thinking about the people they will leave behind in life and unfinished business, plans, and dreams, and bidding farewell to these, constitute some of the fundamental challenges of this period for patients. In this stage, in addition to the discomfort caused by the illness itself, patients must cope with the distress arising from their dependence on the care of others, as well as with anxiety and fears related to the moment of death. During this period, receiving psychological and spiritual support in addition to medical treatment may provide relief for the patient. Reflecting on one's own death and confronting it within one's inner world is not easy. However, talking about the fear of death in all its aspects, expressing fears and anxieties, and having others witness these feelings and thoughts can alleviate this heavy psychological burden. During this period, not only patients but also their relatives may be in need of support. In addition to the difficulties related to caregiving, the possibility of losing a loved one—who is usually a family member—the anxieties regarding how the course of the illness will proceed, and witnessing the suffering of a loved one due to the disease are all extremely exhausting for patients' relatives. On the other hand, witnessing the deterioration and death of other patients in the hospital environment may also act as a factor that further increases already existing anxieties (Kahraman Erkuş, 2021, p. 205).

Terminal-stage patients do not always consist solely of adults. Since healthcare services provided to children differ from those for adults, they are generally treated in separate units within healthcare institutions. For this reason, pediatric palliative care units have been established for terminally ill children. In most cases, parents accompany their children in these units. For parents, having a child

who is a terminal-stage patient is an extremely painful situation. After the death of his daughter Sophie, Freud (1917) stated that the death of a child before their parent is a terrible thing. It is the most difficult loss a person can be forced to grieve. With the death of a child, parents lose not only a very precious bond but also the future they had envisioned. For this reason, the grief of losing a child is so painful as to seem almost unbearable. The death of a child may disrupt the balance within the family. While family members struggle to make sense of the loss and find it difficult to express feelings of anger and guilt, the loss may either bring the family together or lead to irreparable fragmentation among them (Volkan-Zintl, 2019, p. 99). For parents, even if the child is an adult at the time of death, the loss is still perceived as untimely. This loss confronts the parents with what feels like a meaningless task: continuing life without their child. On the other hand, an individual who has lost a spouse also loses a companion, a helper, a source of security, the mother or father of their children, their spousal identity, and their future; therefore, it is expected that they will experience the grief process in a profound and prolonged manner (Zara, 2011, p. 75; Waugh et al., 2018, p. 2).

The Psychology of Grief

The term *mourning* is defined as a broad range of psychological processes that begin with the loss of a loved person (Bowlby, 2015, p. 31). The concept of grief was first defined in psychology in Freud's article *"Mourning and Melancholia"* as a process consisting of the loss of interest in the external world and painful emotions. In this study, Freud argues that during the mourning process all psychic energy is invested in the lost person and their memories. When the individual comes to accept the loss, this energy is withdrawn. According to Freud, mourning is completed with the total withdrawal of this energy directed toward the loved object (1917, p. 254). According to psychoanalysis, the psychological pain caused by loss and the ensuing grief resemble the body's being wounded and the subsequent healing of that wound (Keser, 2021, p. 3).

There are various types of losses in life; however, death is the most concrete and observable of these (Volkan-Zintl, 2019, p. 13). Every separation and loss gives rise to intense anxiety, helplessness, loneliness, and feelings of being lost. The anxiety that emerges after the loss is experienced together with deep sorrow and a longing to reunite with the deceased. For the bereaved individual, the desire to be reunited with the lost person can sometimes become so intense that they may even wish for their own death in order to reunite (Prigerson et al., 2009, p. 12). In this case, in order to be able to adapt to life again, grief must be experienced and completed. When grief progresses along its natural course, the individual can complete the grieving process and learn to live with the loss by making it a part of their life. In order to understand the phenomenon of grief, three fundamental elements must be understood. First, loss inevitably leads a person into sorrow. Second, every loss reactivates past losses. Third, fully grieving each loss serves as a means of growth and renewal (Volkan-Zintl, 2019, p. 12).

Grief does not mean forgetting the one who has been lost. On the contrary, grief means that the individual accepts the loss and the emotions associated with it, copes with the difficulties brought about by the loss, and succeeds in continuing life without the deceased by acknowledging that they will not return. On the other hand, grief is not a disease but a natural reaction to loss. However, the naturalness of grief does not mean that it is an easily manageable process. Grief is a multidimensional process that concerns every area of an individual's life. At the end of this natural process, individuals restructure their lives through new bonds and relationships. Indeed, during or as a result of the grieving process, individuals may even experience growth and development (Göka, 2018, p. 151). When a person truly grieves, they may learn things about themselves and about being human that they did not know before. What the individual learns not only enables them to gain greater psychological maturity but also helps them to make peace with life. Although it is not easy to believe that a painful experience of loss contributes to human development, the individual personally experiences the reality of this (Volkan-Zintl, 2019, p. 14).

There are differing views regarding the experience of the grief process. Early psychological theorists stated that individuals who experience loss go through the grief process with similar internal experiences and symptoms and that the process is universal. Some contemporary theorists, on the other hand, insist that each individual's grief is unique (Keser, 2021, p. 4). Certainly, due to the universal nature of the experience of grief, many people feel similar emotions while struggling with loss. Every separation and loss initiates the grieving process. Factors such as the value of what is lost for the individual and the manner of the loss determine the intensity of grief (Göka, 2018, pp. 146, 153). However, it is also accepted that the work of mourning progresses in a form that is unique to the individual. For this reason, there is no single correct formula or effective prescription for successful mourning (Volkan-Zintl, 2019, p. 13). People's grief is as individual as their fingerprints and is shaped by their past experiences of loss and the characteristics of their relationships with those they have lost. The nature of grief is highly complex. Even within the same family, each person's sorrow may develop quite differently. The expression "psychological wound" is used to describe loss. Similar to the healing of a physical wound, the course of grief may vary depending on factors such as preparedness for the loss, the characteristics of the deceased person, the psychological resilience of the bereaved individual, and their capacity to experience sorrow. The individual's age, gender, manner of expressing emotions, and coping skills are also counted among the characteristics that influence grief reactions and the course of the grieving process (Bowlby, 2015, p. 47; Volkan-Zintl, 2019, p. 20).

Since the work of mourning is a process that progresses with intense feelings of sorrow, it is extremely exhausting. It is not possible to deny grief in mourning. Denial is as absurd as ignoring a broken bone (Volkan-Zintl, 2019, p. 13). However, sorrow also has a consoling aspect. During the work of mourning, sorrow enables the continuation of the bond with the lost person (Volkan-Zintl, 2019, p. 37). The most common and universal reaction to loss is sadness, yet mourning involves much more than sadness alone (Keser, 2021, p. 16). For example, the repetitive thinking about the

deceased person observed in bereaved individuals who are exposed to intense mental preoccupation in the face of loss also constitutes a part of grief (Keser, 2021, p. 14). While repeated reviews occur in consciousness, it becomes inevitable to confront the reality of loneliness and longing, accompanied by the feeling of being surrounded by the past (Volkan-Zintl, 2019, p. 37). One of the most prominent effects of a loss experience is the feeling of "diminishment" and "irreparability" (Keser, 2021, p. 29). Another reaction observed in bereaved individuals is guilt. Feelings of guilt may be a reflection of anger directed at the self, or they may develop due to the thought, "They died, but I am alive." For these individuals, guilt may become more palpable when good things happen in their lives or when they enjoy themselves (Keser, 2021, p. 20). Drawing attention to the serious similarities between grief and depression, Freud (1917, p. 244) stated that while there is no impairment in self-esteem in mourning, the other findings are the same as in melancholia (depression). The difference between the two is that in mourning the individual perceives the world as empty and impoverished, whereas in depression the individual feels themselves to be empty and impoverished (Küçükkaya, 2009, p. 10; Bildik, 2013, p. 224; Göka, 2018, p. 137).

Dreaming about the deceased is also a frequently encountered situation during the grieving process. It is suggested that especially the theme of the deceased person asking for food or drink in dreams may indicate the denial of the loss or that the farewell has not yet been completed. It is argued that dreams are a natural part of the grieving process and help to alleviate the pain of loss (Mallon, 2005, p. 43). Volkan and Zintl (2010, p. 40) state that through dreams, grieving individuals reflect their desire to keep the deceased alive, reveal various internal conflicts such as anger and bargaining, and that dreaming about the deceased is a part of grief itself. Dreams are expected during the grief process and continue with a gradual decrease in the later stages of mourning (Keser, 2021, p. 24).

Grief is not merely an emotional process in which intense distressing feelings are experienced; it is also a cognitive process that requires cognitive and behavioral adaptation to the consequences of the loss. During the grieving process, it is not sufficient to normalize only the emotions related to grief; change is also needed at the cognitive, emotional, and ideational levels. In this process, it may be necessary to reconsider pre-loss meanings and purposes and to construct new meanings. However, this effort of cognitive reappraisal and restructuring is itself a painful process. On the other hand, in addition to coping with the stress caused by the death event, there are also cognitive tasks in grief such as maintaining the bond with the deceased person (Malkinson, 2001, pp. 673–674).

Although the grieving process is a natural process, since it is quite difficult to experience and complete, time, courage, and support are needed for healing. When the grieving process is completed, it is expected that the individual will make the loss a part of their life and learn to live with it. When the loss is traumatic, completing the mourning process becomes even more important for the individual to be able to continue life in a normal and healthy way. Indeed, it is observed that those who experience traumatic loss and avoid mourning or who chronify their grief develop

physical and psychological disorders and are unable to maintain their normal life activities in a healthy manner (Zara, 2011, p. 74).

Stages of the Grief Process

Grief is a process with stages, which is expected to result in the individual's return to at least the level of equilibrium that existed prior to the loss. In early studies on grief, it was assumed that normal grief progressed in stages and in a linear manner. In other words, the prevailing view was that "grief is very painful at first, this pain decreases over time, and the individual begins to feel better." Today, however, the view that grief may be experienced in a chaotic and circular manner has gained greater acceptance (Küçükkaya, 2009, p. 10; Bildik, 2013, p. 224; Göka, 2018, p. 137). With regard to this stage, it is stated that "nothing in grief remains as it is. The individual thinks that they have moved out of a stage, yet that stage may surprisingly recur and return again and again" (Volkan-Zintl, 2019, p. 24).

Volkan-Zintl conceptualizes mourning in two stages: the initial period and the work of mourning. The first stage is the grief experienced during the crisis period, which begins at the moment when the loss or the threat of loss (e.g., a diagnosis of a fatal illness) occurs. The body and mind resist grief; as a consequence of avoiding confrontation with death, the individual moves in and out of states such as denial, bargaining, and anger. When the painful reality is internalized, the crisis period ends and the mourning period begins. It is assumed that the grief process ends with the acceptance of death; however, on the contrary, what begins is the second stage of mourning. After the reality of death is accepted, the relationship with the deceased is reorganized, and the subtle and complex work of reconciliation required to transform the deceased into a memory begins (Volkan-Zintl, 2019, p. 21).

Based on a study conducted with terminal-stage patients, the Swiss physician Kübler-Ross (2010, p. 48) proposed that the grief process consists of five stages. She states that the patients' first reaction is "disbelief, denial, and rejection." This is usually a temporary defense and soon turns into partial acceptance. Sometimes denial accompanies disbelief. Denial may serve as a buffer by preventing shock in the face of loss. It may initially absorb the impact of the shock and help the individual to gradually digest a harsh reality (Küçükkaya, 2009, p. 9; Göka, 2018, p. 156). Funeral rituals may function to confront the bereaved individual with reality and thus to bring denial to an end (Volkan-Zintl, 2019, p. 25; Hökelekli, 2025, p. 115).

In the second stage, when denial can no longer be sustained, it gives way to emotions such as anger, jealousy, and resentment. Some individuals may even feel anger toward the deceased, believing that they will not be able to live without them. At times, anger may be displaced and directed toward healthcare personnel or family members. If the grieving individuals believe in God, they may also feel anger toward Him. One of the most unhealthy grief reactions is directing anger toward oneself (Kübler-Ross, 2010, p. 59; Küçükkaya, 2009, p. 9; Volkan-Zintl, 2019, p. 29; Hökelekli, 2025, p. 115; Keser, 2021, p. 19).

The third stage is bargaining, in which an attempt is made to negotiate with God. This stage, which carries the purpose of postponing the end, is likened to a rejected child promising to be a "good child" in order to have their wish fulfilled (Kübler-Ross, 2010, pp. 89–91; Hökelekli, 2025, pp. 115–116).

The fourth stage is depression. Numbness and anger are replaced by a profound sense of loss and sorrow. One reason why the patient experiences depressive feelings at this stage is exhaustion from what has been endured, while another is the awareness of impending departure from this world (Kübler-Ross, 2010, pp. 93–94; Hökelekli, 2025, p. 116).

The final stage is acceptance. Although this stage is not a "happy ending," it is described as "the last rest before a long journey." If the patient has had sufficient time or has received help for coping in the previous stages, they reach a phase in which they are no longer angry or distressed about their fate. However, emotional numbness is observed at this stage. For those who have long resisted the inevitability of death, attaining peace and tranquility and reaching the final stage is quite difficult (Kübler-Ross, 2010, pp. 119–121; Hökelekli, 2025, p. 116).

Engel (1961), who is well known for his studies on grief, defines the process as "the period until functions return to normal." He speaks of three stages of grief: "shock and denial," "acceptance of the loss experience in the course of time," and "reorganization." According to this view, although grief is accepted as a natural process that is expected to resolve spontaneously, the individual's vital functions may return fully or nearly fully; however, insufficient recovery may also be observed. Bowlby (2015), on the other hand, states that the grief process consists of four stages. In the first stage, there is "a general state of numbness, interrupted by sudden outbursts of anger, which may last for hours or days"; in the second stage, "a prolonged search for the deceased lasting for months"; in the third stage, "disorganization, disintegration, and despair"; and in the final stage, "reorganization and the completion of grief".

According to Göka, the grief process consists of four stages. In the first stage, "numbness and protest" are experienced, and the stage is dominated by tension, fear, and anger. The second stage is the stage of "searching for and longing for the lost person." In this stage, the individual perceives the world as empty and meaningless, constantly thinks about the lost person, cries, and outwardly expresses their anger and restlessness. The third stage is the stage of "psychological disorganization and hopelessness." In this stage, physical preoccupations increase, and restlessness and helplessness are felt. The fourth stage is the stage of "recovery," in which the bereaved individual creates new purposes for their life (Göka, 2018, p. 155).

Zara states that the grief process consists of five stages. The first is the stage of "shock and numbness," in which a brief state of numbness is experienced as a result of confronting the reality of death at the initial moment when the loss is learned. The second is "disbelief and denial," during which the bereaved individual rejects the reality of loss for a period of time and behaves as if nothing has happened. The third is the stage of "yearning," dominated by feelings of loneliness and anger, in which there is a wish for the lost loved one to return. The fourth is "helplessness," in which feelings

of helplessness are experienced as the reality of loss is accepted and its consequences are understood. The fifth is the stage of "acceptance and restructuring life," in which the reality of death/loss is now accepted, the variety and intensity of grief reactions decrease, and normal life functions return to order (Zara, 2011, pp. 79–80).

In Worden's "Tasks of Mourning Model," the grief process is addressed not as a process consisting of fixed stages, as in the other models, but rather as a set of fundamental tasks that the individual must accomplish in order to complete their grief. These tasks are listed as follows (Worden, 2008, pp. 39–52):

1. **To accept the reality of the loss:** This refers to the bereaved individual's full acceptance of the fact that the deceased will not return. Although cognitive acceptance may occur in the early period, emotional acceptance is a process that takes time.
2. **To process the pain of grief and express emotions:** Accepting the pain is an essential task in the grief process. Since grief is completed through experiencing and working through the pain, the individual's avoidance of pain or attempts to suppress or block it lead to a prolongation of the grief process. After the pain is experienced, an inner sense of relief is expected to emerge. The expression of emotions constitutes another part of the healing process. Over time, the frequency of experiencing these emotions is expected to decrease. However, special days such as death anniversaries may reawaken the pain.
3. **To adjust to a world without the deceased:** The bereaved individual must adapt to the loss of the role that the deceased played in their life and to the changes this loss has created in their sense of self. At the end of the grief process, when individuals make sense of these changes and redefine the purpose of life, they may experience personal growth.
4. **To find an enduring emotional connection with the deceased while continuing life:** Redirecting the emotional energy invested in the deceased toward other relationships and personal interests in life is described as a fundamental task to be fulfilled in this process. The bereaved individual must form a conscious memory representation of the deceased and prevent this process from negatively affecting future plans. According to Worden, the grief process is completed when the bereaved individual can think about the deceased without suffering pain. However, this does not mean completely severing all bonds with the deceased. Rather, it means placing the memories and thoughts of the deceased in an appropriate place within one's emotional world and continuing the rest of one's life in this way. This stage is considered the most difficult among the tasks of mourning.

Reconstructing Meaning in the Grief Process

One of the tasks that individuals must complete in order to bring the grief process to a close is adapting to life without the deceased loved one. One of the basic components of this adaptation is the reconstruction of meaning. Certain events that befall a person in life raise feelings of meaninglessness or bring the search for meaning to the forefront. Among the situations in which

questioning about meaning becomes unavoidable and impossible to postpone are the losses that individuals experience (Okay, 2021, p. 105). The death of a loved one can turn into an experience that shakes, or even destroys, a person's world of meaning. Thoughts such as "What is the point of living without him/her? My world has become utterly empty" can have a deeply unsettling impact on one's meaning world (Keser, 2021, p. 31).

With the loss, the individual's life story may begin to fade and become blurred. The world of meaning they have constructed up to that point is shaken. When the loss involves someone close, or when it is sudden, the disruption in the world of meaning is even more severe (Okay, 2021, p. 106). According to narrative approaches, people exist through their own life stories. For this story to be meaningful, there must be people who have borne witness to it from the beginning. When a loss occurs, not only a loved one is lost but also a witness to that story. Therefore, the story must be rewritten and the meaning of life reconstructed (Keser, 2021, p. 2).

The problem of meaning is a psychological process that is extremely difficult for the individual to resolve (Okay, 2021, p. 104). Confronted with meaninglessness, the individual enters an active search for meaning, triggered by existential anxieties. Meaning is personal, and each individual constructs the meaning of their own life (Okay, 2021, p. 103). Meaning can be considered of two types: cosmic/global meaning and earthly/situational meaning. Cosmic/global meaning is related to the purpose of the existence of the universe and humankind, whereas earthly/situational meaning concerns the question, "What is the purpose of *my* existence?" When there is a discrepancy between these two worlds of meaning, the problem of meaning surfaces. The feeling of meaninglessness brought about by loss is among the factors that trigger the search for meaning. The effort to resolve the incompatibility between the individual's cosmic/global meaning world and their earthly/situational meaning world constitutes an important dimension of the grief process (Okay, 2021, p. 102). Healing occurs when the bereaved reconstructs their meaning world and re-establishes harmony. This experience fulfills an important function for the individual's psychological transformation and development. By constructing meaning at the end of the grief process, the individual learns to make new plans without the person they have mourned, to reorganize identity and relationships, and to re-evaluate dreams and beliefs (Okay, 2021, pp. 108–110).

The process of reconstructing meaning after loss occurs in two ways. Either the individual brings the earthly/situational meaning derived from the event into harmony with their cosmic/global meaning world, or they reshape their cosmic/global meaning world in line with the earthly/situational meaning. This process may result in three possible outcomes: the bereaved person's meaning world may be reorganized; meaning may assume a form that is entirely different from before; or no change may occur in the meaning world. The individual who reconstructs the meaning disrupted by the loss can redefine or relearn the world and the self. The person whose meaning world has been shaken may mourn their former meaning world and begin to repair the safe haven that was destroyed together with the loss. They then reconstruct meaning and thus continue their life. For the bereaved individual, the process of reconstructing meaning is both a

farewell and a process of construction. Through the discovery of meaning, the person reorganizes their life story (Okay, 2021, pp. 108–109).

According to the "Meaning Reconstruction" model developed by Neimeyer and Anderson, this process consists of three components. By accomplishing these three grief tasks, the bereaved individual attempts to make sense of the loss and integrate it into life. These are:

1. **Making meaning:** This is the effort to understand why the death occurred. Questions such as "Why did he/she die? Why did this happen to him/her?" are signs that the process of meaning-making has begun. The answers given to these questions—such as "His/her time was up (belief in destiny)","He/she was ill and old"—are attempts to meet the need to make sense and to cognitively situate the loss.
2. **Finding benefit in the loss:** The second component of meaning-making is the ability to see positive aspects of the loss. Believing that the deceased did not suffer when dying, that their suffering ended with death, or that the person was released from illness at the time of death are examples of positive reappraisal. In this way, the bereaved can see a ray of hope in tragedy, draw lessons from the experience, feel stronger after the loss, develop new worldviews, and become more empathetic toward others. This change is usually recognized months or years after the loss.
3. **Identity change:** The final component of meaning reconstruction is identity change. After the loss, the individual loses a part of their identity. They may need to assume the roles previously carried by the deceased. The individual may come to view themselves as more resilient and patient, and as more positive, tolerant, and empathic in relationships. Although the deceased is no longer physically present, through the internalization of their values and memories, they continue to exist within the identity of the bereaved. This process entails an evolution from loving the person in their presence to loving them in their absence. When a loved one is lost, love takes the form of grief. Memories of the deceased are recalled from time to time, and their teachings about life continue to be applied. In this way, the deceased continues to exist in the life of the bereaved and is, in a sense, rendered immortal (Neimeyer & Anderson, 2002, pp. 48–51).

Losses activate existential anxieties and confront people with their own fragility, transience, and mortality (Keser, 2021, p. 9). Through the reconstruction of meaning, the shock, sorrow, regret, depression, and intense longing experienced after the loss gradually diminish; the reality of death is accepted; and the bereaved person's hope and desire for life are renewed. This has been described with the metaphor "being washed ashore while almost drowning" (Okay, 2021, p. 113). Grief rituals, which vary according to socio-cultural contexts, also contribute to the meaning-making of loss (Neimeyer et al., 2002, p. 237). In Turkish–Islamic culture, funeral prayers, condolence visits, expressions of sympathy, prayers recited for the deceased, *mevlid* ceremonies, and communal meals are funeral rituals that, on the one hand, help bereaved individuals construct meaning and, on the other, provide appropriate settings for receiving social support. Through the reconstruction of

meaning during the grief process, changes overlapping with post-traumatic growth may occur. An increase in the value the bereaved attaches to life after the loss, making sense of the loss within their belief system, feeling stronger and more mature as a result of struggling with pain, and placing greater value on relationships in the awareness that loved ones may be lost at any moment—all of these are signs of such growth (Gillies et al., 2014, p. 208).

For human beings, anything in life can be a potential source of meaning, and they may derive meaning from more than one source. A potential source of meaning offers a person a purpose in life, provides values that tell them how they should behave and in which direction they should move, and helps them to feel worthy. To reach the goal presented by their source of meaning, the person must make active efforts, and this in turn supports a sense of self-efficacy. In this context, religious beliefs provide a framework that explains the world in a coherent and systematic way and offer answers to existential, fundamental, and difficult questions that may be asked in life. Thus, religion becomes an important source of meaning for individuals with religious commitment (Okay, 2021, p. 121).

Meaning-oriented psychotherapy approaches are beneficial in resolving meaning crises experienced by individuals. Most meaning-oriented psychotherapy interventions are based on Viktor Frankl's (1963) logotherapy. With the development of the positive psychology movement, as the view that psychotherapies should go beyond psychological disorders and strengthen positive experiences has become widespread, interest in meaning-oriented interventions has increased. Neimeyer's intervention of "meaning reconstruction after loss" is one such example. The aim of this psychotherapy intervention, which is implemented in the form of group therapy, is to help bereaved individuals make sense of the loss and to enable them to discover their personal, relational, and spiritual sources of meaning that give them strength. It also seeks to support them in identifying the lessons that can be drawn from life after the loss and the positive aspects of the loss (Neimeyer & Anderson, 2002). However, every person and every meaning are unique; the therapist is merely a guide. The following stages may be followed in therapy:

1. **Stage:** An exercise of talking about the loss, the place of the deceased, and memories of the deceased.
2. **Stage:** An exercise in which the bereaved writes a letter to the deceased and receives a letter "from" the deceased.
3. **Stage:** The bereaved is asked to write a story using words given to them. This story does not need to be related to real life; it may be written symbolically in the form of a virtual dream. In this way, the bereaved has the opportunity to discover feelings that are not consciously available or are difficult to express verbally (Neimeyer, 2016, p. 75).

Grief and Spirituality

When confronted with the reality of death, people turn more frequently to religion and spirituality; thus they may find ways to make sense of what they are experiencing, develop

explanations for death, and gain the strength to continue living. Religion and spirituality are among the factors that help cope with the grieving process. Religion and spirituality are among the factors positively associated with acceptance of death and the individual's readaptation to life (Brady et al., 1999, p. 417; Başer, 2018, p. 92). It is particularly observed that, during the stage of making sense of the loss, the frequency of religious attributions and the use of religious coping methods increases. Religious beliefs encompass positive psychological potentials such as providing solidarity, optimism, and hope, as well as offering positive views on life after death, recommending patience, and encouraging trust and reliance (*tevekkül*) on the Creator. Göka (2018, pp. 194–195) notes that, while trying to preserve their systems of meaning, individuals may have thoughts such as "God does not burden anyone with a load they cannot bear," "There must be a divine purpose in God allowing this event to happen to me," and that such thoughts facilitate acceptance of the loss. The belief that "there is good in every misfortune," although difficult, helps to understand the positive developments that the loss brings into the individual's life. Even when a person cannot find a positive explanation or meaning, their belief in God and trust in Him provide an important anchor for believing that positive outcomes may emerge. The belief that what is experienced is "part of a divine plan" and not based on coincidence is among the core tenets of some religions (Yaparel, 1994, p. 285). Thinking that nothing is in vain, that there is a reason for what is experienced, and trying to explain this reason through religious attributions can help the individual manage the grief process.

Even those who feel very little influence of religion in their daily lives enter into the sphere of religious influence when they lose a loved one or attend a funeral. Volkan and Zintl (2010, p. 25) draw attention to the fact that religious rituals such as funeral prayers and burial practices confront the individual with the reality of death and foster submission to the current situation. Funeral ceremonies are among the primary religious rituals associated with grief. When different religions are examined, it is seen that funerals are held in a religious setting and that the final duty toward the deceased is performed in a sacred place. Religious individuals generally learn from their religion how they should respond and what kind of attitude they should adopt when their loved ones die (Göka, 2018, p. 194). Post-loss religious rituals not only enable the establishment of a relationship with the deceased under the new circumstances, but also facilitate coping with sadness and longing and adapting to the loss (Kara, 2016, p. 262). It is noted that funerals have an effect that makes it easier for the relatives of the deceased to accept death. Good deeds, religious practices, and rituals performed on behalf of the deceased give the bereaved a sense of peace in feeling that they have done something good for the one who has passed away (Göka, 2018, p. 192-194). In such difficult times, individuals who draw support from religion may find consolation, inner peace, and relief. Religious beliefs, practices, and rituals may, by facilitating acceptance—the first task of grief—help individuals to experience a normal grieving process. Studies have shown that religiosity is associated with lower levels of complicated grief reactions (Maraş, 2015, pp. 45–46).

In a study examining the cultural characteristics of coping with grief conducted with 10 American and 10 Turkish women, it was found that Muslim women continued their relationship

with the deceased through religious and cultural rituals such as prayer (*dua*), reciting the Qur'an, seeing the deceased in dreams, visiting the grave, and having a *mevlid* (a religious ceremony) recited in the name of the deceased. Participants believed that these rituals constituted a form of assistance for the deceased in the hereafter. They also stated that, in both maintaining the bond with the deceased and adapting to life along with grief and grief reactions, they were influenced by the religious and cultural aspects of society (Özmen, 2014, pp. 57–58). In an experimental study involving adolescents who had experienced parental loss, in which group-based spiritual counseling using bibliotherapy techniques was provided, a significant decrease was found in the scores of the trauma-related cognitions scale in the experimental group, as well as an increase in positive religious coping and a decrease in negative religious coping (Satan et al., 2018, p. 411).

Religious beliefs do not serve the function of making people forget the loss. However, religion primarily helps to answer the existential questions that arise in the face of death. Individuals who turn to religion during this process receive their greatest support from religion in one of the fundamental tasks of grief: making sense of death, coping with loss, and discovering new meanings. On the other hand, while some individuals who turn to religion during the grief process benefit only from its compensatory and healing functions, others may also benefit from its developmental function through the aid of religious beliefs, worship, and practices. Individuals who make sense of their experiences with the help of religion may, on the one hand, evaluate painful and distressing situations as bearable events and, on the other hand, regard the grief experience as a factor that contributes to personal maturation and religious development.

Spiritual Needs of Patients and Relatives in the Grief Process in Palliative Care

Since palliative care is a unit in which end-of-life care is provided, it is assumed that patients hospitalized there and their relatives have various spiritual needs. One of the aims of spiritual care, which is regarded as a component of palliative care, is to help them meet these spiritual needs (İşbilen, 2023, p. 607). As these individuals, whose vulnerability has increased while facing the reality of death, experience more existential questioning and greater mental preoccupation with death, their level of anxiety rises and religious/spiritual needs naturally emerge. In a study by Ok and colleagues (2019, p. 161), it was found that the state anxiety levels of patients and their relatives were significantly higher than those of the control group, which consisted of hospital staff and healthy individuals. At the same time, it can be said that the foremost need of palliative care patients and their relatives, who have entered the grieving process, is the need to cope with the anticipated loss. It is noted that among the most common problems seen in patients and relatives in hospitals are grief-related sadness, fear of death, and anxiety (Moran et al., 2005, p. 255; Ok et al., 2019, p. 68). Even though the loss has not yet occurred, these individuals have entered the grief process, and therefore their need for religious/spiritual support manifests itself more clearly. According to reports from healthcare personnel, especially patients who receive a diagnosis of a life-threatening illness and terminal-stage patients question their experiences with such questions as "Why did this happen to

me?", "My God, why did You give me this illness?" From this, it may be inferred that patients and their relatives need to find meaning in the problems they encounter through religious/spiritual references (Ok et al., 2019, p. 46).

When providing spiritual support related to the grief process, it should be kept in mind that in some cases the relatives of the patient may need more support than the patient. Since patients hospitalized in palliative care are in the terminal stage, some may not be fully conscious. On the other hand, patients' relatives constitute the group that will continue to need spiritual support after the death as well. It is stated that families of individuals with fatal illnesses need psychological support both during the course of the illness and in the subsequent grief period, since they accompany their loved ones' experiences of illness and death. Studies have shown that religion and spirituality are effective coping mechanisms for relatives, as well as for patients. Religious belief and spirituality, with their protective function, may facilitate the adaptation of patients' relatives in the face of such difficulties (Ok et al., 2019, p. 57). Relatives also need someone to be present with them and support them when their loved one is under heavy treatment conditions, when the patient dies and they enter the grievin process, and when they confront serious illness. The spiritual needs of relatives are similar to those of patients. Ok and colleagues (2019, p. 56) grouped these spiritual needs under seven headings:

1. The need to establish a relationship with the transcendent/God
2. The need to be treated positively
3. The need for hope and gratitude
4. The need to give and receive love
5. The need to review one's beliefs
6. The need for meaning
7. The need to prepare for the patient's death

In a qualitative study by Murray and colleagues (2004, p. 39) involving 149 in-depth interviews conducted with 20 terminal-stage lung patients, 20 patients with end-stage heart failure, and their informal caregivers, patients and relatives, whether they had religious beliefs or not, expressed needs related to "love, meaning, purpose, and transcendence." The study also found that spiritual issues were important for patients and caregivers. Patients and caregivers mentioned such spiritual needs as "feeling anger, fear, pain, doubt, and hopelessness; seeing life as worthless; feeling isolated and unsupported; feeling useless; experiencing a drop in self-confidence and relationship problems; feeling that they had lost control; and asking questions such as 'Where do I belong? What did I do to deserve this illness?'" In another study, it was determined that terminal-stage patients struggle with three spiritual needs: first, to have lived a meaningful life; second, to strive to die in an appropriate way; and third, to find hope for life after death (Doka, 2011, p. 105).

In a study conducted with advanced-stage cancer patients, among the spiritual needs reported were being with their family (80.2%) and praying frequently (50%). While 26% of patients reported at least one unmet spiritual need, participation in religious ceremonies (21.1%) was the most

frequently unmet spiritual need (Yıldırım et al., 2013, p. 157). In a study conducted with relatives of patients, participants stated that they were able to meet only a very small part of their own needs (97%), that they were often unable to express their grief and sorrow (85%), that they did not know how to express their emotions (78%), and that their willingness toward life decreased considerably during this period of uncertainty (81%) (Çetin, 2018, p. 56).

The possibility of death may lead people to question more deeply, and to seek meaning and forgiveness. In a study by Murray and colleagues (2004, p. 44), it was identified that patients and relatives did not generally talk about such issues with healthcare professionals, who were often very busy, and even tried to conceal their spiritual distress. The same study, which also found that these needs were not adequately expressed even within the family, concluded that the use of active listening skills such as empathy and asking questions, and creating environments in which patients and relatives can talk about their hopes and fears, may help meet these needs. Research has found that patients whose spiritual needs are taken into account in healthcare services are discharged earlier and spend less time in intensive care units (Saad-Medeiros, 2016, pp. 2–3; Ok et al., 2019, p. 66). In a study by Balboni and colleagues (2007, p. 2), it was found that patients receiving healthcare services sensitive to spiritual needs had higher quality of life and better psychological adjustment.

In a study carried out with women with breast cancer, it was concluded that spiritually oriented group therapy reduced depression, pain, and distress and increased mood, self-esteem, and social support (Corwin et al., 2012, p. 254; Ok et al., 2019, p. 75). In palliative care, if a spiritual counselor is actively involved with the problems of patients and their relatives and provides spiritual care, both their spiritual needs can be met and, in line with the understanding of holistic healthcare, their quality of life can be improved.

Spiritual Counseling for Patients and Relatives in the Grief Process in Palliative Care

In spiritual counseling services provided to patients hospitalized in palliative care and their relatives, spiritual needs related to the grief process occupy an important place. Spiritual care, which is offered to meet these needs and is regarded as part of holistic care, is a spiritual–psychological helping service that, by using all forms of intervention, aims first to identify, assess, and address patients' and relatives' religious and spiritual needs—such as their sense of meaning and purpose during the illness process, anxiety, self-esteem, and connection with the transcendent—and to deal with their spiritual "wounds," to support the patient's spiritual well-being, to contribute to physical recovery, and thus to help them feel well both physically and psychologically (Ok et al., 2019, p. 149; Doğan, 2019, p. 194).

Spiritual counseling is a voluntary service; however, studies show that the demand for this service is high. Within the scope of pastoral counseling work in New York, Handzo and colleagues (2008, pp. 42–44) conducted a study based on 30,995 visits to patients and their relatives across six religious categories (Catholic, Jewish, Islam, Protestant, Other, and None). In this study, in which they

evaluated religious/spiritual interventions, they found that a broad group—including those with no religious belief—wished to receive spiritual care.

Possible elements of spiritual counseling for patients include performing religious duties, praying, reading religious texts or books, performing acts of worship and some religious rituals together; organizing religious/spiritual activities during sacred times; answering religious questions and offering guidance when asked; assisting with repentance when requested; supporting the expression of faith (such as *shahada*, belief, etc.); supporting the patient's spiritual development; helping them fulfill religious duties; providing religious materials needed by the patient (such as a prayer rug, Qur'an, rosary, etc.); and, under the supervision of healthcare staff, including complementary practices such as relaxation training and religious music therapy (Ok et al., 2019, pp. 70–71). Since relatives go through processes similar to those of patients, spiritual support may also be offered to the families of patients in these units—if they wish—in order to help them cope with their loved one's illness and with their own pain; counseling techniques used with patients can be applied to them as well (Kelly et al., 2006, p. 779; Ok et al., 2019, p. 69).

Ok and colleagues propose that spiritual counseling be carried out in two stages: a general pre-intervention assessment and the intervention itself. In the first stage, by using a "spirituality assessment tool," information is obtained—on the basis of voluntary responses—not only about whether patients wish to receive spiritual counseling, but also about their desires, needs, hopes, spiritual resources, and spiritual distress. In the second stage, an intervention program can be developed in light of the results of this form (Ok et al., 2019, pp. 77–79). It will support the achievement of the aims of counseling if the spiritual counselor acquires information about the personality of the patient or relative to be supported, any existing psychological problems, living conditions, and past experiences that may affect their current situation, and determines the content of spiritual care accordingly. In addition, it is important, in terms of professional competence, that the counselor who will provide spiritual care possess, beyond basic skills such as listening and giving appropriate responses, caregiving qualities such as showing compassion, interest, and attention.

Spiritual counseling skills are listed as follows: "talking with the patient or relative, holding their hand, laughing and crying together, being present when the patient wishes, arranging for an appropriate spiritual care provider if unable to be present for some reason, listening to life stories, offering a safe environment for the expression of anger, guilt, hurt, regret, and fears, encouraging acceptance of these emotions, and avoiding potentially invalidating expressions such as 'This is God's decree, everything will be fine, you shouldn't think like that." If requested, spiritual care may also include bibliotherapy, the measured use of humor and encouraging cheerfulness, prayer, worship, and the use of appropriate music, as well as encouraging preparation for the funeral, listening to the patient's last wishes, and acting as an intermediary in the realization of appropriate wishes—these are all among the supports that may be provided in spiritual care for terminal-stage patients and their relatives (McAfee et al., 2006, p. 20; Ok et al., 2019, p. 78).

One of the spiritual problems of terminal-stage patients is the thought that they are a burden to those who provide their care. This situation, which leads patients to feel guilty, not only negatively affects their psychological state but may sometimes cause them to conceal or postpone their needs (Kahraman Erkuş, 2021, p. 207). Since caregiving is difficult and exhausting, some relatives who become worn out during this process may express complaints, and patients, when they perceive this, may feel discomfort. In order to prevent patients from feeling guilty about receiving care, this problem can be addressed in a spiritual counseling session that involves the relative as well. The spiritual counselor can inform the relative, support them by explaining the spiritual value of what they are doing, and speak appropriately with the patient to help resolve the issue. Moreover, helping patients and relatives become aware of and express their emotions can strengthen their perception of receiving spiritual support (Ok et al., 2019, pp. 85–86; Handzo, 2008, p. 51).

In end-of-life services such as palliative care, spiritual needs may be felt more intensely. Allowing patients and their relatives to benefit from spiritual counseling services despite differences in their forms of belief, and providing appropriate spiritual care, are directly related to the spiritual counselor's competencies. In one study it was found that the rate of spiritual interventions given to non-religious patients was comparable to the rate of interventions given to religious patients. Therefore, the need for spiritual care should not be viewed as a need exclusive to the religious (Ok et al., 2019, p. 87; Handzo, 2008, p. 50).

Working with patients and relatives in the terminal-stage grief process and providing them with healthcare services may, by reminding healthcare personnel of their own mortality, lead them to experience death anxiety (Ok et al., 2019, p. 58). Even if healthcare staff are not themselves in a grief process, because they frequently encounter the deaths of others and witness grief processes, they may repeatedly feel the need to re-evaluate their own deaths and to question the meaning of their lives anew. Consequently, it may be necessary to include personnel working in palliative care and intensive care units in spiritual care programs conducted by spiritual counselors (McAfee et al., 2006, p. 19). In a study where hospital staff were asked whether patients needed spiritual care, it was found that those who held generally positive attitudes toward spirituality also had a favorable view of both the current and the ideal forms of spiritual care. Furthermore, the study showed that, regardless of whether their attitudes toward spirituality were positive or negative, hospital staff agreed that spiritual care is a need. It was also generally accepted that, among patient groups, those in oncology and palliative care units require more spiritual care. The possibility that hospital staff themselves may need spiritual care was also highlighted among the issues raised in this research (Ok et al., 2019, p. 162).

Spiritual Counseling for the Relatives of Patients in the Post-Death Grief Process

After death has occurred, grief counseling needs to be provided to the relatives of the deceased patient. Spiritual care services for mourning relatives of patients who have passed away may include: talking about the loss; encouraging visits to the grave; helping them express emotions such as anger,

guilt, and helplessness; assisting them in adapting to life without the deceased; supporting them in emotionally locating the deceased and holding on to life through memories; helping them view sorrow and grief as normal experiences; informing them that there may be individual differences in experiencing pain; ensuring continuity in spiritual care support; evaluating the effectiveness of coping methods; and, when necessary, referring them to mental health professionals (Ok et al., 2019, p. 71). From the very beginning, the spiritual counselor can accompany the relatives, conveying the message that they are present and sharing their pain. While the spiritual counselor is not responsible for performing religious funeral rituals, they may, if the relatives so wish, recite prayers or read the Qur'an during the grief process in order to support them.

Post-death spiritual counseling should be shaped according to the needs of the bereaved. For instance, in cases where a loved one has undergone a long illness, has no hope of recovery, and is thought to have suffered greatly, relatives may experience a sense of relief when that person dies. Thoughts such as "His/her suffering has ended; he/she is freed" may contribute to this relief, as may the sudden cessation of the intense anxiety relatives felt for the patient. However, after this feeling of relief, bereaved individuals may experience guilt (Keser, 2021, p. 33). The spiritual counselor can support the bereaved by explaining that feeling relief in such circumstances is among the normal grief reactions and by helping them not to blame themselves for it.

In our country, funeral rituals such as the funeral prayer and burial procedures are generally conducted by male relatives. Female relatives of the deceased typically do not take part in this process, assuming that it is a task specific to men. This is a practice determined by tradition rather than by any religious rule. Based on the knowledge that funeral rituals can assist in the acceptance of the loss during the grief process, it can be said that women should not be excluded from this process, that their participation in the funeral prayer, and even, where possible, their witnessing stages such as burial, would be beneficial for their grief processes. Indeed, women who lack knowledge on this subject may even think that participating in these rituals would be sinful. If they wish, the spiritual counselor can inform the relatives of the deceased that they may participate in funeral rituals.

Faith-Based Spiritual Counseling for Coping With Grief in Palliative Care

a. Spiritual Counseling Aimed at Coping With Grief Through Faith

In struggling with the difficulties of life, people seek support from their beliefs. When they encounter situations beyond their strength and feel helpless, they turn to God, activating their belief in His power. At this point, not only the strength of the individual's faith but also their image of God shapes the way this turning occurs. For the patient and relative who are confronted with the reality of death and the task of coping with grief, belief in God may be a factor that increases endurance. Belief in God is strengthened when it is nourished by feelings such as love, respect, and trust. Trust is the most fundamental emotion in faith. Religious individuals who possess a strong sense of trust toward the One in whom they believe and who have strong attachment are more

inclined to make positive evaluations when they feel the need to make sense of what befalls them, whereas those whose dominating emotion is fear may be more inclined toward negative evaluations. Those with a strong sense of trust feel more intensely the Creator's compassion, mercy, and forgiveness toward them, while those whose trust is weak may think that the Creator does not love them, does not respond to their prayers, and may interpret what happens to them as a punishment. At this point, it is a highly important spiritual intervention for the spiritual counselor to step in and guide the counselee from negative religious coping toward positive religious coping. Indeed, numerous studies have shown that negative religious coping is associated with adverse psychological indicators.

Modern grief research shows that people's continuing to maintain a bond with the deceased and to feel in contact with them contributes to their well-being. Here, beliefs of religions concerning the afterlife are of particular significance. Belief that death is not an end, that the deceased are not annihilated but continue their existence in another dimension, enables bereaved individuals to sustain their relationship with the deceased. Another positive effect of belief in the hereafter is its role in reducing anxiety about death. For example, bereaved parents may believe that their children are waiting for them in Paradise and long for this reunion. It is observed that those who lose a child, on the one hand, increase in wisdom during this difficult process and, on the other, change in a positive direction spiritually and existentially. In addition, beliefs such as the idea that the deceased child will protect the parents from Hell or intercede for them and be a means for their entrance into Paradise are among the thoughts that provide spiritual relief for bereaved Muslim parents (Doka, 2011, p. 105; Başer, 2018, pp. 95, 97).

Religious individuals who draw support from faith in the process of meaning-making may interpret the loss in terms of destiny (*kader*), think that the deceased has gone to Paradise and that God has taken them to Himself, that if the deceased suffered for a long time, death was a release for them, and that they are now in a good place and have found peace. However, although rarely, there are also examples of bereaved individuals displaying negative attitudes toward religious thoughts and practices. An individual who experiences loss may cling more tightly to their beliefs, but they may also distance themselves from their faith, question their belief in God, and reassess their religious convictions (Göka, 2018, p. 172; Okay, 2021, p. 115). The spiritual counselor must be prepared for such reactions. Indeed, the anger experienced during the grief process may sometimes be directed toward religion and God. Spiritual counseling, which is provided upon the request of the patient and relative, already includes interventions aimed at individuals experiencing such crises of faith.

Among the topics of spiritual counseling for dying patients is helping them resolve doubts that may arise in connection with the difficulties they are experiencing and supporting them in maintaining steadfastness in faith (Ok et al., 2019, p. 86; Handzo, 2008, p. 53). Some individuals with religious belief may, during the grief process, use negative religious coping instruments such as "feeling anger toward God, complaining to Him, thinking their prayers are not accepted, and

believing that God no longer cares about them," and may distance themselves from their religion (Ok et al., 2019, p. 73). Spiritual counseling in this context can help resolve the crisis of faith being experienced.

For patients hospitalized in palliative care and their relatives, anxiety about the approaching end is a major problem that deeply shakes them. The activation of death anxiety, resulting from confrontation with the phenomenon of death, has the potential to affect not only patients and relatives but also the staff providing services in palliative care, including spiritual counselors. On the other hand, confronting death is one of the critical times that leads individuals to turn rapidly toward religion. Whether a person personally faces the danger of death or experiences an event such as the death of a loved one, death confronts the individual with a reality of life that cannot be altered, where human will has no function and control is impossible. In fact, the experience of death is a kind of experience of truth, and this truth is painful.

However, the spiritual counselor, who possesses religious knowledge and resources to alleviate patients' anxieties about the moment of death and what follows, can provide spiritual support at this point. Talking about death—often avoided and treated as a taboo topic—with patients and their relatives may itself be a form of spiritual support. Generally, people tend to deny death by not speaking about it, even when the likelihood is very high. Since not talking about it prevents patients and relatives from moving from the denial stage to the stage of acceptance, the grief process cannot properly begin and is effectively frozen. Yet grief is a process, and one cannot speak of completing a process that has never begun. The spiritual counselor can empathize with them, allow them to share their feelings and thoughts about death, and, through active listening, help alleviate their anxiety.

Rather than using phrases such as "This is God's decree, what can we do; this world is a place of trial," it may be more helpful to emphasize the reality of death, that death is not annihilation but a transition to another dimension, God's love and mercy toward His servants, and the belief that reunion will occur in another realm. By drawing on cultural elements as well as religious/spiritual sources, it is possible, in the face of such a painful situation, to activate belief in the hereafter and destiny at the cognitive level and thus harness the power of faith. Since the basic source of death anxiety is uncertainty, even if this conversation does not completely eliminate uncertainties about the moment of death and its aftermath for patients, or about the loss of a loved one for relatives, the very act of being able to speak about death may have a cathartic and relieving effect.

b. Spiritual Counseling for Coping with Grief Through Religious Practices

In a study conducted with hospitalized patients and their relatives, it was found that patients used positive religious coping at a higher level than their relatives, whereas hospital staff used negative religious coping more frequently than both patients and their relatives (Ok et al., 2019, p. 162). Religious practices may also function as positive religious coping tools. In this context, prayer is one of the most fundamental instruments of spiritual counseling, and numerous studies provide ample evidence of the positive effects of prayer in difficult times of life. Research has shown that

most patients who request spiritual care consider prayer to be important (Ok et al., 2019, p. 77). Among the spiritual needs of palliative care patients and their relatives is also the need for prayer. Prayers performed together may alleviate the anxiety of these individuals, whose anxiety levels are high.

The spiritual counselor's offering a special prayer for the patient and relatives, or informing them that he/she will pray for them, and healthcare personnel such as physicians and nurses praying for the patient's healing and ease at the encouragement of the spiritual counselor, may also reveal the positive effects of intercessory prayer. If the patient and relatives so wish, performing a prayer of repentance together with the spiritual counselor may not only meet a spiritual need such as forgiveness, but also relieve them from the oppressive burden of guilt feelings. In certain health-related situations and special interventions, prayer is used as an effective coping tool in spiritual counseling. Very often, especially before surgery or at the stage of entering the dying process, prayer becomes the method most frequently used by counselors in providing spiritual support. Although the conditions of patients and relatives differ, one of the most common requests they jointly express from the spiritual counselor is prayer (Handzo et al., 2008, p. 46; Ok et al., 2019, p. 85).

Reading from the sacred text and discussing it are also among the religious rituals that may psychologically comfort patients and their relatives. When the Qur'an is read by the spiritual counselor in a beautiful voice and melody, while reminding them that it is a source of healing, and when its meaning is also read and explained, this may activate both the emotional and cognitive dimensions of faith and contribute to psychological well-being. Special-day and night programs in which palliative care staff may also participate can provide opportunities for meeting spiritual needs and offering spiritual support through religious practices by means of group spiritual counseling.

c. Spiritual Counseling for Coping with Grief Through Values

Values such as patience, gratitude, forgiveness, hope, and love may help individuals in the grief process to cope. In this context, the love shown by the spiritual counselor to the patient and relatives may help establish a relationship based on trust and also meet a spiritual–psychological need (Temiz, 2017, p. 346). The religious/spiritual value of patience in the face of difficulties may be recalled by the spiritual counselor, and it may be emphasized that being patient in such difficult times—when it is truly hard—is itself a virtue. By clarifying the difference between patience and mere endurance and emphasizing the importance of patience being shown voluntarily rather than compulsorily, the counselor may underscore its moral worth. By also referring to research findings showing that psychological well-being increases when patience is practiced in this way, patients and relatives may be encouraged to include patience among their coping tools.

Since hope is a virtue that enhances patience, instilling hope in patients and their relatives may increase their well-being, even though there may be situations that appear hopeless. Even for patients who have reached the terminal stage, physicians may say, "One should never lose hope in God," and it is often observed that relatives search for a miraculous medicine. This is because, even

if the situation is critical, the experience of loss is never a completely prepared-for or timely one (Keser, 2021, p. 6). In such patients, hope may persist. While at first this hope may take the form of hope for recovery, for not suffering, or for the discovery of a new treatment, later it may transform into hope for prolongation of life or for a peaceful death (Kahraman Erkuş, 2021, p. 207). Religious individuals, believing that their illness is in divine hands, may always feel that there is hope for a miraculous intervention. Furthermore, they may value life as a higher good than the potential harms of aggressive attempts to sustain it (Balboni et al., 2007, p. 6).

The critical point here is that unrealistic hope should not be given to the patient—for example by saying "You will get better"—and, on the other hand, if the patient or relatives already have unrealistic hope, that hope should not be taken away from them either. Sometimes clinging to even a very small hope may make them feel better. Gratitude, on the other hand, has the potential to transform negative emotions into positive ones and is therefore among the coping tools that may have a positive effect during the grief process. However, rather than offering evaluative statements such as "Be grateful that your situation is like this," it will be a more effective approach for the spiritual counselor to use practices such as a gratitude journal so that individuals themselves may become aware of their reasons for gratitude.

The need to forgive and to be forgiven is also among the spiritual needs felt during the grief process. The spiritual counselor may emphasize the importance of putting this value into practice by speaking about the psychological benefits of forgiveness for the person who forgives. If patients or relatives feel guilt because of a wrongdoing toward someone, they may be encouraged to seek forgiveness (*helallik*) from that person so as to relieve themselves of the intense pressure of guilt. In spiritual counseling sessions, some practical exercises may be carried out to meet the needs for forgiveness and being forgiven. Consistent with cultural practices of reconciliation, appropriate settings may be created for patients and relatives. Especially since the patient's feeling of being a burden to the caregiver is a significant source of distress, the explicit expression by the relative that they forgive the patient may be soothing and relieving for the patient. In spiritual counseling, including examples of coping with the grief process through values and making references to the virtuous conduct of prophets and religious figures in the face of hardship may help patients and their relatives to incorporate values into their coping tools.

d. Spiritual Counseling for Coping with Grief Through Social Support

One of the most important tools for coping with the grief process is social support. In palliative care, one of the most important forms of support that the spiritual counselor provides to patients and their relatives is regular visitation. Compared with other hospital units, palliative care units involve longer periods of hospitalization. While relatives who serve as caregivers may occasionally leave the hospital environment, patients generally cannot do so. Therefore, patient visits carry a much greater meaning for them than for other patient groups. Visits conducted by the spiritual counselor sometimes alone and sometimes together with other spiritual counselors, social workers,

or psychologists may ensure the continuity of both religious/spiritual and social support during the grief process for patients and their relatives.

In order to increase social support, the spiritual counselor may also meet with friends, neighbors, and relatives whom the patient and relatives would enjoy seeing and encourage them to visit. Especially the positive relationships of the patient's relatives with their social environment may help alleviate the pain of possible negative developments related to the patient. When patients in palliative care are forced to remain isolated due to their illness, the problem of loneliness may also emerge. Since hospital conditions restrict visitation, the hospital spiritual counselor's freedom to visit may contribute to meeting the socialization needs of palliative care patients and their relatives. The spiritual counselor, to some extent, also fulfills people's need to talk. Talking about illness is one of the important strategies for coping with it. Even if physicians talk sufficiently with their patients, patients often complain that they cannot talk freely with their doctors. However, speaking about illness is a need for both patients and their relatives. Finding even a small ray of hope may become possible through talking (Ağılkaya, 2017, p. 358).

For this reason, one of the greatest psychological supports that can be provided to a patient is to give them the opportunity to express the problems, contradictions, and losses they are experiencing. Feelings of hope, helplessness, fear, and anxiety may be difficult even to notice, let alone to share. Listening while patients express these is not easy either. In most cases, patients are instead tried to be comforted and calmed (Kahraman Erkuş, 2021, p. 208). When the spiritual counselor explains that denial, splitting, bargaining, guilt, and anger are natural in the grief process, that the work of mourning is both distressing and disruptive to inner balance, and that normal grief may sometimes take on a seemingly strange form, the bereaved individual may feel relieved. Moreover, by removing taboos around talking about death and by providing environments appropriate for the expression of feelings, the spiritual counselor may encourage patients and their relatives to speak and make them feel that they are not alone in this process. Serving the families of those with terminal illnesses, taking an active role in rituals such as funeral prayer and burial, and being sensitive to the need of bereaved individuals to express their pain and anger are also among the possible responsibilities associated with the spiritual counselor (Volkan-Zintl, 2019, p. 115).

Conclusion and Recommendations

In recent years, palliative care has gained significant importance in healthcare services due to the influence of the holistic healthcare approach. The aim of palliative care, which provides healthcare services to patients who no longer have hope for recovery, is not only to offer comfort-oriented medical care but also to enhance the quality of life of patients and their relatives by supporting them psychologically, socially, and spiritually. When patients and their relatives become aware of the approaching end, in addition to the distress caused by the illness, patients may experience various psychological and spiritual difficulties due to the prospect of losing their lives, and relatives due to the prospect of losing a loved one. Although death has not yet occurred, these individuals already

experience the psychology of grief. When people confront the reality of death, their orientation toward religion and spirituality increases.

Individuals in the grief process are able to make sense of their experiences through religion and spirituality, offer explanations for death, cope with grief-related problems, and gain the strength to continue living. Research shows that religion and spirituality are highly effective in coping with the grief process. It is particularly observed that the frequency of making religious attributions and resorting to religious coping methods increases during the stages of making sense of the loss and reconstructing the meaning of life. Since religious beliefs include positive psychological potentials such as solidarity, optimism, hope, gratitude, offering positive views on the afterlife, perceiving positive aspects within adversity, encouraging patience, and trusting and relying on the Creator, they may serve as an important source of spiritual support for bereaved individuals.

In spiritual counseling provided to patients and their relatives in palliative care, needs related to the grief process come to the fore. Fear of death and the need for meaning constitute the primary spiritual needs in this process. The spiritual counselor may provide spiritual care by centering these needs and integrating them with general spiritual counseling interventions directed toward patients and their relatives. However, first of all, the religious and spiritual needs of patients and relatives—such as their sense of meaning and purpose, stress, anxiety, self-acceptance, forgiveness, hope, and connection with the Creator—need to be identified. In addition, it should not be forgotten that the spiritual needs of patients and relatives in the grief process in palliative care may differ in an individual-specific manner. Taking individual differences into consideration while providing spiritual counseling will positively affect the success of the counseling process.

In this study, it is recommended that grief-oriented, coping-based spiritual counseling be provided to patients and their relatives hospitalized in palliative care. One of these is "spiritual counseling aimed at coping with grief through faith." For patients and their relatives who are confronted with the task of grief, "belief in God, belief in the afterlife, and belief in destiny (qadar)" may serve as coping resources. With the love, respect, and trust they feel toward God, religious individuals may make positive evaluations when they feel the need to make sense of what they experience. However, some patients and relatives receiving spiritual counseling may also hold thoughts such as that the Creator does not love them, does not respond to their prayers, or that what has happened to them is a punishment. At this point, it is an important spiritual intervention for the spiritual counselor to step in and guide the counselee from negative religious coping toward positive religious coping. Through belief in the afterlife, the idea that death is not an end, that the deceased are not annihilated but continue their existence in another dimension, may enable them to maintain their bond with the deceased, reduce their anxiety about death, and preserve their hope for reunion. When supported by belief in destiny, they may think that the deceased has gone to Paradise and that God has taken them to His side; if the deceased suffered for a long time, they may interpret death as a deliverance, as the person now being in a better place and at peace. In this way,

patients and their relatives may cope with their grief through their beliefs and experience psychological relief.

Religious practices may also have positive effects on patients and their relatives during the grief process in palliative care. Prayer, which is one of the foremost positive religious coping tools, is among the most fundamental instruments of spiritual counseling. Research has shown that most patients who request spiritual care consider prayer to be important. Religious practices such as reading from the sacred text and engaging in religious activities on sacred times, special days, and nights are also among the coping tools that may provide spiritual support to patients and their relatives during the grief process.

Values have the potential to spiritually support individuals in coping with the difficulties of grief. In this context, values such as patience, gratitude, forgiveness, hope, and love may serve as effective coping tools in spiritual counseling for the grief process. Openly demonstrating love to patients and their relatives may help spiritual counselors establish trust-based relationships with their counselees. The spiritual counselor may remind them of the religious/spiritual value of patience in the face of hardship and of gratitude, which has the potential to transform negative emotions into positive ones. The value of hope needs to be incorporated into spiritual counseling interventions with great care. A spiritual counselor may encounter patients who, despite being in the terminal stage, believe that a new medication will be discovered and that they will recover, or relatives who entertain strong hope for the patient's recovery. In such cases, it is important that hope be framed in ways that provide positive spiritual support for patients and relatives—such as hope for the acceptance of prayers, freedom from suffering, and forgiveness. The need for forgiveness and being forgiven is also among the spiritual needs in the grief process. Offering patients and relatives hope that they will be forgiven, speaking about the psychological benefits of forgiveness for the individual, and emphasizing the value the Creator places on forgiveness may encourage these individuals toward forgiveness and allow the positive effects of the value of forgiveness to be incorporated into the grief process.

In difficult periods of life, human beings need social support even more. Both being a patient hospitalized in palliative care and being a relative who provides care are extremely demanding roles. Patients and relatives in palliative care are often isolated and experience loneliness. Since patients' opportunities to leave the hospital are almost nonexistent, patient visits are of great value to them. Providing social support to these individuals through regular visits by the spiritual counselor, learning which friends, neighbors, and relatives they would like to see and encouraging such visits, constitutes an important spiritual counseling intervention for coping with the grief process.

Within the context of this study, the following recommendations may be made regarding spiritual counseling services provided in our country. Hospital-based spiritual counseling is one of the most widespread fields of spiritual counseling in Turkey. Under current conditions, hospital spiritual counseling is provided four days a week and during working hours. When assessed under these conditions, it is evident that the spiritual counselor working in palliative care is not always accessible. When crisis moments do not coincide with the days and hours on which spiritual

counseling is provided, patients and their relatives naturally cannot benefit from this service at the times when they need it most. Since palliative care is a continuous healthcare service, assigning spiritual counselors—if necessary with appropriate compensation—on a shift basis, like other healthcare personnel, and thus ensuring continuity of service, may both increase interest in the service and enhance its effectiveness.

Ethics Committee Approval

This study is a theoretical work and does not require ethics committee approval.

Conflict of Interest

The author(s) declare(s) no conflict of interest.

Article History

Received: 09.12.2025
Accepted: 19.02.2026
Published: 30.03.2026

Author Information

Prof. Dr. Mebrure Doğan
Afyon Kocatepe University, Faculty of Theology, Department of Psychology of Religion.
https://orcid.org/0000-0002-9027-144X
mebruredogan@gmail.com

References

Ağılkaya, Ş. Z. (2017). *Manevi bakım ve danışmanlık*. Marmara Akademi Yayınları.

Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, M. E., Lathan, C. S., Peteet, J. R. ve Prigerson, H. G. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology, 25*(5), 555–560. https://doi.org/10.1200/JCO.2006.07.9046

Başer, B. N. (2018). Spiritual counseling for bereaved parents. *Spiritual Psychology and Counseling, 3*, 85–106.

Bildik, T. (2013). Ölüm, kayıp, yas ve patolojik yas. *Ege Tıp Dergisi, 52*(4), 223–229.

Bowen, G. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*. https://doi.org/10.3316/QRJ0902027

Bowlby, J. (2015). *Kaybetme* (N. Nirven ve N. Diner, Çev.). Pinhan Yayıncılık.

Brady, M. J., Peterman, A. H., Fitchett, G., Mo, M. ve Cella, D. (1999). A case for including spirituality in quality of life measurement in oncology. *Psycho-Oncology, 8*(5), 417–428. https://doi.org/10.1002/(SICI)1099-1611(199909/10)8:5<417::AID-PON398>3.0.CO;2-4

Corwin, D., Wall, K. ve Koopman, C. (2012). Psycho-spiritual integrative therapy: Psychological intervention for women with breast cancer. *Journal for Specialists in Group Work, 37*(3), 252–273. https://doi.org/10.1080/01933922.2012.686961

Çetin, H. (2018). Kayıp yaşarken fonksiyon kaybı tüm acılarımızın nedeni. *Uluslararası Katılımlı Palyatif Bakım ve Hospis Kongresi Kongre Kitapçığı*. http://www.palyatif.org/bildiri-kitabi.pdf

Devictor, D. ve Carnevale, F. (2008). Improving end-of-life care in the pediatric intensive care unit. *Therapy, 5*(4), 387–390.

Doğan, M. (2019). Palyatif bakımda manevî desteğin hasta yakınlarının psikolojik iyi oluşuna etkisinin incelenmesi. A. Ayten, H. Ekşi, M. Zengin ve N. Tınaz (Ed.), In *Sağlık hizmetlerinde manevi danışmanlık ve rehberlik* (ss. 187–217). Dem Yayınları.

Doka, K. J. (2011). Religion and spirituality: Assessment and intervention. *Journal of Social Work in End-of-Life & Palliative Care, 7*, 99–109.

Engel, G. L. (1961). Is grief a disease? A challenge for medical research. *Psychosomatic Medicine, 23*, 18–22.

Frankl, V. E. (1963). *Man's search for meaning: An introduction to logotherapy*. Washington Square Press.

Freud, S. (1917). Mourning and melancholia. J. Strachey (Ed. ve Çev.), In *The standard edition of the complete psychological works of Sigmund Freud* (Cilt 14, ss. 237–258). Hogarth Press.

Gillies, J. ve Neimeyer, R. A. (2006). Loss, grief, and the search for significance: Toward a model of meaning reconstruction in bereavement. *Journal of Constructivist Psychology, 19*, 31–65.

Gillies, J., Neimeyer, R. A. ve Milman, E. (2014). The meaning of loss codebook: Construction of a system for analyzing meanings made in bereavement. *Death Studies, 38*(4), 207–216. https://doi.org/10.1080/07481187.2013.829367

Göka, E. (2018). *Hoşçakal*. Kapı Yayınları.

Handzo, G. F., Flannelly, K. J., Kudler, T., Fogg, S. L., Harding, S. R., Hasan, Y. H., Ross, A. M. ve Taylor, B. E. (2008). What do chaplains really do? II. Interventions in the New York Chaplaincy Study. *Journal of Health Care Chaplaincy, 14*(1), 39–56. https://doi.org/10.1080/08854720802053853

Hökelekli, H. (2025). *Yaşam ölüm ölümsüzlük*. Anadolu Ay Yayınları.

İşbilen, N. (2023). Manevi danışmanlık üzerine fenomenolojik bir analiz: Morristown Tıp Merkezi Healthcare Chaplaincy (ABD) örneği. *Ankara Üniversitesi İlahiyat Fakültesi Dergisi*, *64*(2), 591–628. https://doi.org/10.33227/auifd.1353314

Kahraman Erkuş, Ö. (2021). Kanser hastalarının yas süreci. E. Keser (Ed.), In *Kayıp ve yas psikolojisi* (ss. 197–227). Nobel Yayıncılık.

Kara, E. (2016). Yas süreci ve dini danışmanlık. *Dokuz Eylül Üniversitesi İlahiyat Fakültesi Dergisi Din Psikolojisi Özel Sayısı*, 251–270.

Kelly, B., McClement, S. ve Chochinov, H. M. (2006). Measurement of psychological distress in palliative care. *Palliative Medicine, 20*(8), 779–789. https://doi.org/10.1177/0269216306072347

Keser, E. (2021). Kayıp, yas ve yas belirtileri. E. Keser (Ed.), In *Kayıp ve yas psikolojisi* (ss. 1–45). Nobel Yayıncılık.

Kübler-Ross, E. (2010). *Ölüm ve ölmek üzerine* (E. Uşşaklı, Çev.). April Yayıncılık.

Küçükkaya, G. P. (2009). Kayıp ve yas süreci. *Hemşirelikte Eğitim ve Araştırma Dergisi, 6*(1), 8–13.

Malkinson, R. (2001). Cognitive-behavioral therapy of grief: A review and application. *Research on Social Work Practice, 11*(6), 671–698.

Mallon, B. (2005). Dreams and bereavement. *Bereavement Care, 24*(3), 43–46. https://doi.org/10.1080/02682620508657635

Maraş, A. (2014). Komplike yas: Derleme ve vaka çalışması. *AYNA Klinik Psikoloji Dergisi*, (11), 41–59.

McAfee, C., Cochrane, B., Waldron, M., Hasson, F. ve Kernohan, G. (2006). Chaplains working in a

hospice palliative care team recount the spiritual challenges at the end-of-life. *Health and Social Care Chaplaincy*, *9*(2), 18–24.

Moran, M., Flannelly, K. J., Weaver, A. J., Overvold, J. A., Hess, W. ve Wilson, J. C. (2005). A study of pastoral care, referral, and consultation practices among clergy in four settings in the New York City area. *Pastoral Psychology*, *53*(3), 255–266. https://doi.org/10.1007/s11089-004-0556-3

Murray, S. A., Kendall, M., Boyd, K., Worth, A. ve Benton, T. F. (2004). Exploring the spiritual needs of people dying of lung cancer or heart failure: A prospective qualitative interview study of patients and their carers. *Palliative Medicine*, *18*(1), 39–45. https://doi.org/10.1191/0269216304pm837oa

Neimeyer, R. A. (2016). Meaning reconstruction in the wake of loss: Evolution of a research program. *Behaviour Change*, *33*(2), 65–79. https://doi.org/10.1017/bec.2016.4

Neimeyer, R. A. ve Anderson, A. (2002). Meaning reconstruction theory. N. Thompson ve J. Campling (Ed.), In *Loss and grief*. Palgrave. https://doi.org/10.1007/978-1-4039-1404-0_4

Neimeyer, R. A., Prigerson, H. G. ve Davies, B. (2002). Mourning and meaning. *American Behavioral Scientist*, *46*(2), 235–251. https://doi.org/10.1177/000276402236676

Nelson-Becker, H. (2013). Spirituality in end-of-life and palliative care: What matters? *Journal of Social Work in End-of-Life & Palliative Care*, *9*, 112–116.

Ok, Ü., Gedik, Z. ve Erşahin, Z. (2019). *Hastalar için manevi bakım*. Nobel Yayıncılık.

Okay, D. (2021). Yas ve anlamı yeniden yapılandırma. E. Keser (Ed.), In *Kayıp ve yas psikolojisi* (ss. 99–146). Nobel Yayıncılık.

Özmen, O. (2014). *Kayıp yaşamış yetişkin kadınlarda kayıp ve yasla baş etmenin kültürel özellikleri: Uzlaşımsal nitel analize dayalı olgusal bir araştırma* [Yayımlanmamış doktora tezi]. ODTÜ Sosyal Bilimler Enstitüsü.

Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M. et al. (2009). Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Medicine*, *6*(8), 1–12. https://doi.org/10.1371/journal.pmed.1000121

Saad, M. ve de Medeiros, R. (2016). Programs of religious/spiritual support in hospitals: Five "whys" and five "hows." *Philosophy, Ethics, and Humanities in Medicine*, *11*(1), 5. https://doi.org/10.1186/s13010-016-0039-z

Satan, A., Çıplak, K., Kaplaner, O. ve Erol, F. (2018). Ebeveyn kaybı yaşamış ergenlerde bibliyoterapi yönelimli manevi danışmanlık uygulaması. A. Ayten, M. Koç ve N. Tınaz (Ed.), In *Manevi danışmanlık ve rehberlik* (Cilt 1) (ss. 397–413). Dem Yayınları.

Siddall, P. J., Lovell, M. ve MacLeod, R. (2015). Spirituality: What is its role in pain medicine? *Pain Medicine*, *16*, 51–60.

Temiz, Y. E. (2017). Erdem temelli müdahalelerin dini danışmanlık ve rehberliğe katkısı: Pozitif psikoloji yaklaşımı. A. Ayten (Ed.), In *Manevi danışmanlık ve rehberlik: Teori ve uygulama alanları* (ss. 301–352). Dem Yayınları.

Volkan, V. D. ve Zintl, E. (2019). *Kayıptan sonra yaşam: Komplike yas ve tedavisi*. Pusula Yayınevi.

Waugh, A., Kiemle, G. ve Slade, P. (2018). What aspects of post-traumatic growth are experienced by bereaved parents? A systematic review. *European Journal of Psychotraumatology*, *9*, 1–14.

WHO. (2025). *Palliative care*. https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/palliative-care

Worden, J. W. (2008). *Grief counseling and grief therapy: A handbook for the mental health practitioner*. Springer Publishing Company.

Yaparel, R. (1994). Depresyon ve dini inançlar ile tabiatüstü nedensel yüklemeler arasındaki ilişkiler. *Dokuz Eylül Üniversitesi İlahiyat Fakültesi Dergisi*, (8), 275–299.

Yıldırım, N. K., Kaçmaz, N. ve Özkan, M. (2013). İleri evre kanser hastalarının karşılanmamış bakım gereksinimleri. *Psikiyatri Hemşireliği Dergisi, 4*(3), 153–158.

Zara, A. (2011). Kayıplar, yas tepkileri ve yas süreci. A. Zara (Ed.), In *Yaşadıkça*. İmge Yayıncılık.