



Journal Website

Article history:

Received 02 March 2026

Revised 08 July 2026

Accepted 16 July 2026

Published online 30 July 2026

International Journal of Education and Cognitive Sciences

Volume 7, Issue 4, pp 1-15



E-ISSN: 3041-8828

Comparing the Effectiveness of Metacognitive Therapy and Narrative Reconstruction on Dysfunctional Attitudes and Grief Symptoms in Women with Prolonged Grief Disorder

Soheila. Saeed¹, Ghodratollah. Abbasi^{2*}, Bahram. Mirzaian²

¹ Ph.D. Student, Department of Psychology, Sar.C., Islamic Azad University, Sari, Iran

² Department of Psychology, Sar.C., Islamic Azad University, Sari, Iran

* Corresponding author email address: gh_abbasi@iausari.ac.ir

Article Info

ABSTRACT

Article type:

Original Research

How to cite this article:

Saeed, S., Abbasi, G., & Mirzaian, B. (2026). Comparing the Effectiveness of Metacognitive Therapy and Narrative Reconstruction on Dysfunctional Attitudes and Grief Symptoms in Women with Prolonged Grief Disorder. *International Journal of Education and Cognitive Sciences*, 7(4), 1-15.

<https://doi.org/10.61838/kman.ijecs.456>



© 2026 the authors. Published by Iranian Association for Intelligence and Talent Studies, Tehran, Iran. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial 4.0 International (CC BY-NC 4.0) License.

Purpose: This study aimed to compare the effectiveness of Metacognitive Therapy (MCT) and Narrative Reconstruction (NR) in reducing dysfunctional attitudes and grief symptoms among women diagnosed with Prolonged Grief Disorder (PGD).

Methods and Materials: This quasi-experimental study employed a pre-test, post-test, and three-month follow-up design with a wait-list control group. The statistical population comprised women attending psychological clinics in Western Tehran during 2024–2025. Forty-five eligible participants were selected through purposive sampling and randomly allocated to MCT, NR, and control groups ($n = 15$ each). The two experimental groups received ten sessions of their respective interventions, whereas the control group received no intervention during the study period. Data were collected using the Dysfunctional Attitudes Scale (DAS-26) and the Prolonged Grief Disorder-13 (PG-13) scale. Mixed-design analysis of variance and Bonferroni post-hoc comparisons were performed using SPSS version 26.

Findings: Mixed ANOVA revealed significant time-by-group interaction effects for dysfunctional attitudes, $F(4,84) = 33.71$, $p < .001$, $\eta^2 = .616$, and grief symptoms, $F(4,84) = 9.63$, $p < .001$, $\eta^2 = .314$. Bonferroni comparisons showed that both MCT and NR significantly reduced dysfunctional attitudes compared with the control group ($MD = 23.435$ and 39.697 , respectively; $p < .001$). NR was also significantly more effective than MCT in reducing dysfunctional attitudes ($MD = 16.262$, $p < .001$). Both MCT and NR significantly reduced grief symptoms relative to the control group ($MD = 3.180$ and 4.179 , respectively; $p < .001$); however, the difference between the two interventions was not statistically significant ($MD = 0.999$, $p = .192$).

Conclusion: Both MCT and NR are effective interventions for reducing prolonged grief symptoms in women with PGD, whereas NR appears to have greater efficacy in modifying dysfunctional attitudes and underlying maladaptive cognitive schemas. These findings support selecting psychotherapeutic approaches according to the dominant cognitive and emotional mechanisms maintaining prolonged grief.

Keywords: Prolonged Grief Disorder; Metacognitive Therapy; Narrative Reconstruction; Dysfunctional Attitudes; Grief Symptoms.

1. Introduction

The death of a significant person is among the most consequential and emotionally demanding experiences in human life. Bereavement typically involves intense sadness, yearning, disruption of daily routines, changes in social roles, and a need to reorganize personal identity and assumptions about the future. For many individuals, these reactions gradually diminish as the reality of the loss becomes integrated into autobiographical memory and everyday functioning. However, for a clinically important subgroup of bereaved people, grief remains persistent, intense, and functionally impairing well beyond the period in which adaptation would ordinarily be expected. Contemporary research has increasingly recognized that such enduring reactions constitute a distinct clinical condition rather than merely a severe form of normative grief. The growing scientific understanding of grief as an adaptive process involving coordinated changes in cognition, emotion, behavior, physiology, and social functioning has contributed substantially to the formal recognition of Prolonged Grief Disorder (PGD) and to efforts to develop targeted psychological interventions for affected individuals (O'Connor, 2019). The validation of diagnostic criteria for PGD and related assessment instruments has further strengthened the distinction between prolonged grief and other conditions such as depression and post-traumatic stress, emphasizing persistent yearning, preoccupation with the deceased, identity disruption, emotional pain, difficulty reintegrating into life, and functional impairment as central characteristics of the disorder (Prigerson et al., 2021).

PGD is clinically significant because the distress associated with persistent grief is not limited to sadness about the absence of the deceased. Rather, the disorder often involves a broader failure to cognitively and emotionally integrate the loss into the individual's continuing life narrative. Individuals may remain psychologically oriented toward the deceased, repeatedly revisit circumstances surrounding the death, struggle to accept its finality, avoid reminders of the loss, or become unable to imagine a meaningful future. These patterns can maintain emotional suffering and restrict engagement with relationships, occupational activities, and personally valued goals. Consequently, the treatment of PGD requires more than the simple reduction of negative affect; therapeutic interventions must address the psychological processes that prevent accommodation of the loss and interfere with the

restoration of adaptive functioning. Recent systematic evidence indicates that psychotherapeutic interventions can produce meaningful reductions in prolonged grief symptoms, although treatment approaches vary considerably in their theoretical assumptions and their proposed mechanisms of therapeutic change (Srivastava et al., 2025). This variability has increased interest in identifying which psychological processes should be targeted and whether different interventions may be especially effective for particular cognitive and emotional dimensions of PGD.

One important cognitive factor that may contribute to persistent psychological distress after bereavement is the presence of dysfunctional attitudes. Dysfunctional attitudes are relatively stable maladaptive assumptions and beliefs regarding personal worth, interpersonal approval, achievement, vulnerability, dependency, and control. Such beliefs influence how individuals interpret stressful events and may intensify distress when major life experiences challenge established assumptions. Following the death of a loved one, dysfunctional beliefs can become particularly salient because bereavement may threaten the individual's perceived competence, security, identity, and expectations concerning the future. Beliefs such as being unable to cope independently, being permanently damaged by the loss, being responsible for what occurred, or being incapable of experiencing meaning or satisfaction again may reinforce emotional suffering and interfere with adaptive grief processing. Evidence from psychological intervention research indicates that dysfunctional attitudes are modifiable cognitive structures and that their reduction can accompany improvements in broader emotional functioning (Ebrahimi et al., 2013). More recent research has similarly emphasized the importance of modifying rigid maladaptive attitudes in emotionally distressed women, suggesting that interventions addressing self-related cognitive structures can produce meaningful psychological change (Fahami & Abed, 2026).

Within the context of PGD, dysfunctional attitudes may be particularly important because they can interact with repetitive negative thinking, avoidance, impaired meaning-making, and fragmented representations of the loss. A person who interprets persistent grief as uncontrollable, dangerous, or necessary for maintaining a bond with the deceased may become increasingly engaged in rumination and self-focused attention. Likewise, a person whose identity has been strongly organized around the lost relationship may develop rigid conclusions about personal worth, future possibilities, or the meaning of life after the death. These cognitive structures may therefore serve both

as consequences of the loss and as mechanisms that prolong maladaptive grief responses. Clinical studies in PGD have demonstrated that psychological interventions can improve processes closely connected to these patterns, including rumination, emotion regulation, coping self-efficacy, cognitive fusion, and self-compassion (Abbasian & Sahragard, 2024; Daraei et al., 2025). Such findings support the broader proposition that persistent grief is maintained not only by the emotional intensity of bereavement but also by the ways in which loss-related thoughts, beliefs, memories, and meanings are processed.

Metacognitive Therapy (MCT) offers one theoretical and clinical approach for addressing these maintaining mechanisms. In contrast to conventional cognitive interventions that primarily challenge the content of maladaptive thoughts, metacognitive approaches emphasize the processes through which individuals attend to, interpret, and respond to their own thinking. A central assumption is that psychological distress is maintained by repetitive patterns such as worry, rumination, threat monitoring, and ineffective attempts to control cognition. These processes are supported by positive metacognitive beliefs, such as the belief that prolonged thinking is useful or necessary, and negative metacognitive beliefs, such as the belief that thoughts are uncontrollable or dangerous. In bereavement, these processes may manifest as repetitive analysis of the death, persistent questioning of causes and consequences, ongoing monitoring for reminders of the deceased, or attempts to suppress distressing memories. Such patterns can maintain psychological activation while preventing more flexible emotional adaptation.

The clinical relevance of metacognitive approaches to prolonged grief has been demonstrated directly. A pilot randomized controlled trial of MCT for prolonged grief provided evidence that metacognitive intervention can reduce grief-related distress by targeting maladaptive patterns of repetitive thinking and metacognitive beliefs (Wenn et al., 2019). This is particularly important because rumination is frequently implicated in the maintenance of persistent grief and may interfere with natural adaptation by repeatedly reactivating loss-related emotional states. Rather than asking patients to debate the truth of every painful cognition, MCT seeks to help them disengage from unproductive cognitive processing, develop greater attentional flexibility, and experience thoughts as mental events rather than signals that require extended analysis. Techniques such as detached mindfulness, attention modification, behavioral experiments, and the restructuring

of beliefs about uncontrollability and danger may therefore reduce the cognitive-attentional patterns that sustain PGD.

The broader literature also supports the potential utility of metacognitive interventions across psychological conditions characterized by repetitive cognition and maladaptive self-processing. Metacognitive training has shown promise in reducing depressive symptoms and improving cognitive-emotional functioning among older adults (Silva et al., 2026), while metacognitive techniques have also been applied to concerns such as body dissatisfaction, demonstrating their capacity to modify maladaptive patterns of attention and thought processing (Naz et al., 2026). Similarly, developments in metacognitive interpersonal therapy have highlighted the therapeutic importance of experiential work, metacognitive understanding, and the therapeutic relationship in complex clinical presentations (Dimaggio et al., 2025). Case-based applications of metacognitive interpersonal approaches in individuals with multiple psychiatric and personality-related difficulties further illustrate the adaptability of metacognitive principles to complex patterns of self-experience and emotional dysregulation (Fioravanti et al., 2026). Although these studies are not specific to PGD, they collectively reinforce the proposition that altering how individuals relate to their thoughts can produce clinically meaningful changes across different forms of psychological distress.

A conceptually distinct but potentially complementary approach is Narrative Reconstruction (NR). Narrative approaches are based on the premise that people understand their lives through organized stories that provide continuity between past experiences, present identity, and anticipated future possibilities. Major losses can disrupt this narrative organization by challenging fundamental assumptions about relationships, security, identity, purpose, and personal continuity. When a death is traumatic, unexpected, or psychologically overwhelming, memories may remain fragmented, emotionally intense, or poorly integrated into the individual's broader autobiographical system. Instead of becoming a painful but incorporated part of personal history, the loss may remain psychologically dominant and continue to organize the person's emotional life around what has been lost.

Narrative Reconstruction seeks to facilitate adaptation by helping individuals construct a more coherent representation of the loss experience, integrate previously fragmented memories, and revise the personal meanings associated with bereavement. In contrast to approaches that focus primarily on reducing the frequency of distressing thoughts, narrative

reconstruction directly engages with the content and organization of the loss narrative. The individual is encouraged to revisit, elaborate, organize, and reinterpret the experience so that the event can be incorporated into a broader life story. This process can facilitate meaning-making, reduce avoidance, increase emotional processing, and support the reconstruction of identity after loss. Narrative-focused interventions are therefore particularly relevant to dysfunctional attitudes because maladaptive beliefs may be embedded within the individual's interpretation of what the loss means about the self, the deceased, relationships, responsibility, safety, and the future.

Empirical evidence for narrative approaches in prolonged grief has grown in recent years. A pilot study of Narrative Reconstruction Therapy for PGD provided initial support for its feasibility and therapeutic effectiveness (Elinger et al., 2021). Subsequent quasi-experimental research demonstrated symptomatic improvement alongside enhanced integration of loss-related memories, providing support for the proposed mechanism through which narrative reconstruction may facilitate recovery (Elinger et al., 2023). These findings are important because memory integration represents more than simple recollection; it involves organizing the event within a coherent autobiographical framework that enables the bereaved individual to acknowledge the reality of the loss while maintaining continuity of identity and future orientation. Narrative therapy research has likewise shown beneficial effects among individuals experiencing prolonged grief, supporting its use as a structured intervention for facilitating adaptation to bereavement (Babar et al., 2024).

Other strands of grief research also reinforce the importance of narrative processes and meaning reconstruction. Art and narrative therapy programs have been associated with constructive changes in participants' experiences of grief and bereavement, suggesting that expressive and narrative processes may support emotional processing and the reorganization of loss-related experience (Nelson et al., 2022). Therapeutic writing has similarly been examined in mothers who experienced early pregnancy loss, with findings emphasizing narrative well-being and the potential value of constructing language and meaning around emotionally painful experiences (de Paiva et al., 2025). Strength-based narrative therapy has also been associated with reductions in depressive symptoms and improvements in quality of life among older adults, further supporting the capacity of narrative approaches to influence psychological functioning beyond grief-specific contexts

(Zhu et al., 2025). In addition, narrative exposure-based intervention has demonstrated beneficial effects on resilience, mindfulness, and quality of life among individuals with PGD, suggesting that structured engagement with the loss experience may facilitate adaptation across multiple domains of functioning (Rezaei Shahi et al., 2025).

The construct of meaning reconstruction is especially central to contemporary understandings of adaptation to bereavement. Loss often creates a discrepancy between the individual's pre-loss assumptions and post-loss reality, requiring the person to revise personal meanings and develop a new understanding of self and life circumstances. The development and psychometric evaluation of measures such as the Grief and Meaning Reconstruction Inventory reflect increasing recognition of meaning-related processes as measurable components of grief adaptation (Soraci et al., 2025). From this perspective, persistent grief may partly reflect difficulty constructing an acceptable and coherent interpretation of the loss. Narrative approaches can address this difficulty by helping the bereaved individual transform fragmented or rigid loss narratives into more integrated accounts that preserve the significance of the deceased while allowing continued engagement in life.

Recent therapeutic developments have further expanded the evidence supporting meaning-centered and narrative interventions. The Meaning in Loss protocol, evaluated as an online grief therapy intervention, illustrates how structured therapeutic work around meaning can be translated into contemporary treatment formats while retaining a focus on the psychological reconstruction of loss (Batista et al., 2024). Systematic consideration of narrative therapy for complicated grief has likewise emphasized its theoretical and practical relevance for mental health professionals and its capacity to address identity, meaning, emotional processing, and adaptation following bereavement (Santos & Soares, 2024). Together, these findings suggest that narrative interventions are particularly well suited to aspects of PGD involving fragmented memories, disrupted identity, unresolved meaning, and maladaptive cognitive assumptions.

Despite evidence supporting both MCT and narrative-based interventions, an important clinical question concerns whether they exert equivalent effects on all relevant outcomes. The two approaches target different levels of cognitive functioning. MCT principally addresses the regulation of attention and repetitive cognitive processing, seeking to alter how individuals respond to their thoughts.

NR, in contrast, engages more directly with the content, organization, and personal meaning of loss-related experiences. Consequently, both interventions may reduce overall grief symptoms while differing in their effects on deeper dysfunctional beliefs. MCT may reduce emotional distress by weakening rumination and maladaptive metacognitive control strategies, whereas NR may influence dysfunctional attitudes more directly by revising the narrative context in which such beliefs are embedded. This theoretical distinction is clinically important because treatment selection may be improved when interventions are matched to the mechanisms most prominent in a particular patient.

The existing literature nevertheless provides limited direct evidence regarding the comparative effects of MCT and NR on both grief symptoms and dysfunctional attitudes within the same study. Most available research has examined these approaches separately, used different populations and outcome measures, or focused on broader indices such as depression, quality of life, resilience, emotion regulation, meaning reconstruction, or rumination. Moreover, although women frequently experience substantial psychological and relational consequences following bereavement and constitute an important population in clinical grief research, relatively few comparative intervention studies have specifically examined women with PGD while simultaneously assessing symptom severity and maladaptive cognitive structures. A direct comparison of MCT and NR can therefore contribute to the literature by determining whether interventions with different cognitive targets produce comparable changes in core grief symptoms and whether one approach demonstrates greater utility in modifying dysfunctional attitudes.

Accordingly, the aim of the present study was to compare the effectiveness of Metacognitive Therapy and Narrative Reconstruction in reducing dysfunctional attitudes and grief symptoms among women diagnosed with Prolonged Grief Disorder.

2. Methods and Materials

2.1. Study Design and Participants

The present study employed a quasi-experimental design with three assessment points, including pre-test, post-test, and a three-month follow-up, and incorporated two active intervention groups and a wait-list control group. The statistical population consisted of women attending psychological clinics in Western Tehran during 2024–2025

who met the diagnostic and eligibility criteria for Prolonged Grief Disorder (PGD). The required sample size was estimated using G*Power software, version 3.1, assuming a medium effect size of 0.25, an alpha level of 0.05, and a statistical power of 0.95. Based on these parameters and consideration of previous research in this field, a total sample of 45 participants was considered adequate. Participants were initially recruited through purposive sampling according to predefined inclusion and exclusion criteria and were subsequently randomly allocated to three equal groups of 15 participants: a Metacognitive Therapy (MCT) group, a Narrative Reconstruction (NR) group, and a wait-list control group. The inclusion criteria were being female, being between 18 and 45 years of age, having at least a high school diploma, having experienced the death of a loved one at least 12 months before enrollment in the study, and obtaining a score above 30 on the Prolonged Grief Disorder Scale (PG-13). Participants were excluded if they were simultaneously receiving another psychological or psychotherapeutic intervention, presented with active suicidal ideation or intent as determined through clinical interview, had severe comorbid psychiatric or physical conditions that could interfere with participation in the intervention, or were absent from more than two treatment sessions. Following enrollment and group allocation, all participants completed the study measures at baseline. The two experimental groups then received their respective 10-session interventions, whereas the control group remained on a waiting list and received no psychological intervention during the study period. The post-test was administered immediately after completion of the interventions, and all three groups were reassessed three months later to evaluate the maintenance of treatment effects. Ethical principles were observed throughout the research process. Participants received information regarding the study procedures and voluntarily provided informed consent before participation. Confidentiality was protected through anonymization and coding of the collected data, participation imposed no financial burden, and the procedures were implemented with consideration of relevant cultural and religious norms. After completion of the study, participants in the wait-list control group were provided with a brief psychoeducational summary, and the findings were explained to participants who expressed an interest in receiving information about their results.

2.2. Data Collection Tools

Dysfunctional Attitudes Scale (DAS-26). Dysfunctional attitudes were assessed using the 26-item version of the Dysfunctional Attitudes Scale (DAS-26), developed within the framework of Beck's cognitive theory to evaluate maladaptive cognitive assumptions and beliefs associated with psychological distress. The instrument assesses dysfunctional attitudes across four principal domains: perfectionism or performance evaluation, need for approval, need to please others, and vulnerability. Participants indicate the extent to which they agree or disagree with each statement using a 7-point Likert-type response format, with higher overall scores representing stronger and more pervasive dysfunctional attitudes. The scale is intended to capture relatively stable maladaptive assumptions concerning personal worth, achievement, interpersonal acceptance, dependency, and vulnerability to negative events. Previous psychometric investigations have demonstrated satisfactory convergent validity through associations with established measures of depressive symptoms, mood disturbance, and cognitive distortions. Evidence from Iranian samples has also supported the psychometric adequacy of the instrument. Ebrahimi et al. (2013) confirmed its convergent validity in an Iranian population, and an internal consistency coefficient of 0.92 has been reported for the 26-item version, indicating a high degree of reliability. In the present study, the DAS-26 served as the primary measure of changes in maladaptive cognitive structures across the pre-test, post-test, and three-month follow-up assessments.

Prolonged Grief Disorder Scale (PG-13). The severity of prolonged grief symptoms was assessed using the Prolonged Grief Disorder Scale (PG-13), a measure designed to evaluate symptoms associated with prolonged grief and to facilitate identification of individuals presenting clinically significant grief reactions. The instrument contains 10 symptom items rated on a 5-point Likert scale ranging from 1, indicating "not at all," to 5, indicating "very much," together with three additional yes/no screening items that are not incorporated into the total severity score. The symptom items assess clinically relevant manifestations of prolonged grief, including persistent yearning for or preoccupation with the deceased, identity disruption, disbelief, avoidance of reminders of the loss, intense emotional pain, difficulties reintegrating into everyday life, emotional numbness, a sense of meaninglessness, and intense loneliness. The three screening questions address whether a significant

bereavement has occurred, the period of time elapsed since the death, and whether grief-related symptoms are associated with impairment in functioning. Higher total scores indicate greater severity of grief symptoms, and scores above 30 are indicative of probable Prolonged Grief Disorder within the screening framework used in the present investigation. The PG-13 has demonstrated satisfactory reliability and validity as a dimensional assessment of prolonged grief symptoms. Prigerson et al. (2021) reported evidence supporting its psychometric properties, while its validity has also been examined in Iran. Daraei et al. (2025) reported satisfactory validity and an internal consistency coefficient of 0.82 in an Iranian sample. In the current study, Cronbach's alpha for the overall instrument was 0.87, indicating satisfactory internal consistency. The PG-13 was administered at pre-test, post-test, and three-month follow-up and constituted the primary measure for evaluating changes in prolonged grief symptoms.

2.3. Interventions

Metacognitive Therapy. Participants assigned to the Metacognitive Therapy group received a 10-session intervention based on the metacognitive treatment framework of Wells and King (2006). The intervention focused primarily on modifying the maladaptive metacognitive beliefs and cognitive-attentional processes considered responsible for maintaining repetitive grief-related thinking. The initial session was devoted to case formulation and familiarizing participants with the metacognitive treatment model. A thought-suppression experiment involving thoughts and memories related to the deceased was conducted, and participants were introduced to detached mindfulness and worry-postponement techniques as alternative ways of responding to intrusive grief-related cognitions. The second session continued to address beliefs concerning the uncontrollability of thoughts through verbal and behavioral reattribution of grief-related experiences. During the third session, further work was undertaken to modify beliefs about uncontrollability, accompanied by in-session behavioral experiments and identification of maladaptive coping responses and avoidance strategies that maintained distress. The fourth session introduced beliefs concerning the perceived danger of losing control over thoughts and emotions, and participants behaviorally examined feared consequences associated with such loss of control. In the fifth session, danger-related metacognitive beliefs were further

challenged through structured in-session experiments. The sixth session focused on strengthening adaptive alternative responses to grief-related thoughts while systematically reducing maladaptive strategies such as excessive rumination, avoidance, and unhelpful attempts to control cognition. During the seventh session, positive metacognitive beliefs regarding worry and rumination were identified and examined through behavioral experiments. The eighth session continued modification of these positive metacognitive beliefs and incorporated mismatch strategies to demonstrate discrepancies between participants' beliefs about the usefulness of repetitive thinking and its actual emotional consequences. The ninth session addressed residual symptoms, reinforced newly acquired cognitive-processing styles, and initiated relapse-prevention planning. Finally, the tenth session consolidated therapeutic gains, reviewed the continued application of metacognitive strategies in everyday life, and completed a relapse-prevention plan intended to support maintenance of treatment effects after termination. Across the intervention, emphasis was placed on changing participants' relationship with grief-related thoughts rather than directly disputing the factual content of those thoughts, thereby reducing the repetitive cognitive-attentional patterns associated with persistent grief.

Narrative Reconstruction. Participants in the Narrative Reconstruction group received a 10-session intervention based on the narrative reconstruction protocol described by Elinger et al. (2021), which was designed to facilitate integration of distressing loss-related memories and reconstruction of a more coherent autobiographical account of the bereavement. The first session provided psychoeducation regarding the distinction between normal and prolonged grief, introduced participants to the rationale and principles of narrative reconstruction, and prepared them for subsequent memory-focused therapeutic work. In the second session, the participant and therapist identified and selected the most distressing loss-related memory to serve as the principal target of treatment. The third session was devoted to stabilizing the target memory and preparing the participant to engage in a detailed retelling of the event. During the fourth session, the participant began constructing a detailed, minute-by-minute narrative of the loss event, with particular attention to identifying omissions, disruptions, inconsistencies, or gaps in the existing memory representation. The fifth session involved reviewing and extending the narrative through retrieval of previously omitted or insufficiently processed details. In the sixth

session, further elaboration and correction of the account were undertaken to enhance chronological continuity, narrative coherence, and integration of the memory. The seventh session combined continued narrative reconstruction with explicit cognitive and emotional processing of the bereavement experience, allowing participants to examine their interpretations, emotional responses, and meanings associated with the event. In the eighth session, the reconstructed account was integrated with the broader personal significance of the loss, with attention to the implications of the event for the participant's identity, assumptions, relationships, and continuing life narrative. The ninth session involved reviewing the completed narrative and evaluating cognitive and emotional changes that had occurred during the reconstruction process. The tenth and final session consolidated therapeutic gains, provided a comprehensive review of the reconstructed narrative and the changes achieved during treatment, and prepared the participant for termination. Through progressive elaboration and organization of loss-related memories, the intervention sought to transform fragmented and emotionally overwhelming recollections into a coherent autobiographical narrative, thereby promoting cognitive and emotional integration of the loss.

The wait-list control group received no therapeutic intervention during the active treatment phase. Participants in this group completed the same pre-test, post-test, and three-month follow-up assessments as the two intervention groups, thereby allowing changes associated with the two active treatments to be compared with changes occurring in the absence of structured psychotherapy. This design permitted evaluation of both the absolute effects of Metacognitive Therapy and Narrative Reconstruction relative to the control condition and their comparative efficacy in reducing dysfunctional attitudes and prolonged grief symptoms.

2.4. Data Analysis

Data were analyzed using IBM SPSS Statistics, version 26.0. Descriptive statistical procedures, including frequency, percentage, mean, and standard deviation, were used to summarize participants' demographic characteristics and describe scores on dysfunctional attitudes and prolonged grief symptoms at the pre-test, post-test, and three-month follow-up assessments. To examine the primary research hypotheses, a mixed-design analysis of variance (Mixed-Design ANOVA) was performed. This analytical approach

incorporated time as the within-subject factor with three levels—pre-test, post-test, and follow-up—and treatment condition as the between-subject factor with three levels—Metacognitive Therapy, Narrative Reconstruction, and wait-list control. The analysis therefore allowed examination of changes in the dependent variables over time, differences among the study groups, and, most importantly, the time-by-group interaction indicating whether the pattern of change differed according to treatment condition. Before conducting the main inferential analyses, the statistical assumptions underlying mixed-design ANOVA were evaluated. The normality of the score distributions was examined using the Shapiro-Wilk test, homogeneity of error variances across groups was assessed with Levene's test, and equality of covariance matrices was evaluated using Box's M test. The assumption of sphericity for the repeated-measures factor was also examined, and the Greenhouse-Geisser correction was specified for application where violations of sphericity occurred. When statistically significant main effects or time-by-group interaction effects were identified, Bonferroni-adjusted post-hoc pairwise comparisons were conducted to determine the specific differences between Metacognitive Therapy, Narrative Reconstruction, and the control condition while controlling for inflation of Type I error arising from multiple comparisons. All statistical tests were two-tailed, and the threshold for statistical significance was established at $p < .05$.

Table 1*Descriptive Statistics for Dysfunctional Attitudes and Grief Symptoms Across Measurement Stages*

Variable	Group	Pre-test (M ± SD)	Post-test (M ± SD)	Follow-up (M ± SD)
Dysfunctional Attitudes	Control	201.24 ± 10.10	193.07 ± 9.72	192.79 ± 10.97
	MCT	196.98 ± 10.19	164.98 ± 8.89	154.83 ± 7.82
	NR	196.24 ± 7.34	142.21 ± 12.23	129.56 ± 8.14
Grief Symptoms	Control	37.90 ± 2.88	36.62 ± 3.65	36.14 ± 2.86
	MCT	38.32 ± 2.12	31.61 ± 1.70	31.21 ± 1.57
	NR	37.39 ± 2.75	30.49 ± 1.32	30.25 ± 0.68

As shown in Table 1, the three groups had relatively comparable mean scores at the pre-test stage for both dysfunctional attitudes and grief symptoms. However, distinct patterns emerged following the interventions. For dysfunctional attitudes, the mean score in the MCT group decreased from 196.98 (SD = 10.19) at pre-test to 164.98 (SD = 8.89) at post-test and further decreased to 154.83 (SD = 7.82) at follow-up. A larger reduction was observed in the NR group, in which the mean dysfunctional attitudes score decreased from 196.24 (SD = 7.34) at pre-test to 142.21 (SD

3. Findings and Results

The study sample consisted of 45 women diagnosed with Prolonged Grief Disorder (PGD), equally allocated to the Metacognitive Therapy (MCT), Narrative Reconstruction (NR), and wait-list control groups. The mean age of the participants was 31.57 years (SD = 5.77), and the largest proportion of participants belonged to the 30–35-year age group ($n = 16$, 35.55%). Regarding educational attainment, 31 participants (68.89%) held a bachelor's degree, 8 (17.78%) had a high school diploma, and 6 (13.33%) held a master's degree. In terms of marital status, 28 participants (62.22%) were married and 17 (37.78%) were single. Regarding the duration since the death of a loved one, 23 participants (51.11%) had experienced the loss 1–2 years previously, 16 (35.55%) had experienced the loss 2–3 years previously, and 6 (13.33%) had experienced the loss more than three years previously. With respect to economic status, the majority of participants reported a moderate economic status ($n = 29$, 64.44%), while 9 participants (20.00%) reported a low economic status and 7 (15.55%) reported a high economic status. Chi-square analyses indicated no statistically significant differences among the three study groups in demographic characteristics ($p > .05$), supporting the demographic comparability of the groups at baseline.

= 12.23) at post-test and 129.56 (SD = 8.14) at follow-up. In contrast, the control group showed only a comparatively small reduction, from 201.24 (SD = 10.10) at pre-test to 193.07 (SD = 9.72) at post-test and 192.79 (SD = 10.97) at follow-up. A similar pattern was observed for grief symptoms. The mean grief symptom score decreased from 38.32 (SD = 2.12) to 31.61 (SD = 1.70) and 31.21 (SD = 1.57) across the three assessment stages in the MCT group, while in the NR group it decreased from 37.39 (SD = 2.75) to 30.49 (SD = 1.32) and 30.25 (SD = 0.68), respectively.

The control group demonstrated only a slight decline from 37.90 (SD = 2.88) at pre-test to 36.62 (SD = 3.65) at post-test and 36.14 (SD = 2.86) at follow-up. These descriptive findings suggest that both active interventions were associated with reductions in dysfunctional attitudes and grief symptoms and that the observed improvements were maintained through the three-month follow-up period.

Before performing the mixed-design analysis of variance, the assumptions required for parametric analysis were examined. Box's M test indicated that the assumption of equality of covariance matrices was satisfied for both dysfunctional attitudes (Box's M = 15.48, $p = .310$) and grief

symptoms (Box's M = 41.39, $p = .423$). Mauchly's test of sphericity was also nonsignificant for the study variables ($p > .05$), indicating that the sphericity assumption was satisfied. In addition, Levene's tests conducted at the pre-test, post-test, and follow-up stages were nonsignificant for both dependent variables ($p > .05$), supporting the assumption of homogeneity of error variances across the study groups. Accordingly, the required assumptions for conducting mixed-design ANOVA were considered satisfied, and the inferential analyses were subsequently performed using the uncorrected degrees of freedom.

Table 2

Mixed-Design ANOVA Results for Dysfunctional Attitudes and Grief Symptoms

Variable	Source	SS	df	MS	F	p	η^2
Dysfunctional Attitudes	Time	38,589.016	2	19,294.508	182.77	< .001	.813
	Time $\times$ Group	14,235.564	4	3,558.891	33.71	< .001	.616
	Error	8,667.448	84	103.185	—	—	—
Grief Symptoms	Time	799.703	2	399.852	77.85	< .001	.650
	Time $\times$ Group	197.917	4	49.479	9.63	< .001	.314
	Error	431.411	84	5.136	—	—	—

As presented in Table 2, the mixed-design ANOVA revealed a statistically significant main effect of time on dysfunctional attitudes, $F(2, 84) = 182.77$, $p < .001$, $\eta^2 = .813$, indicating substantial changes in dysfunctional attitude scores across the pre-test, post-test, and follow-up assessments. More importantly, the time $\times$ group interaction was also statistically significant, $F(4, 84) = 33.71$, $p < .001$, $\eta^2 = .616$, demonstrating that the pattern of change over time differed significantly among the MCT, NR, and control groups. For grief symptoms, there was likewise a significant

main effect of time, $F(2, 84) = 77.85$, $p < .001$, $\eta^2 = .650$, as well as a significant time $\times$ group interaction, $F(4, 84) = 9.63$, $p < .001$, $\eta^2 = .314$. These findings indicate that grief symptoms changed significantly across the three measurement occasions and that the magnitude of these changes varied according to treatment condition. The significant interaction effects justified subsequent Bonferroni-adjusted pairwise comparisons to identify the specific differences among the study groups.

Table 3

Bonferroni Post-Hoc Pairwise Comparisons Between Study Groups

Variable	Comparison	Mean Difference	SE	p
Dysfunctional Attitudes	Control – MCT	23.435*	1.710	< .001
	Control – NR	39.697*	1.710	< .001
	MCT – NR	16.262*	1.710	< .001
Grief Symptoms	Control – MCT	3.180*	0.525	< .001
	Control – NR	4.179*	0.525	< .001
	MCT – NR	0.999	0.525	.192

As shown in Table 3, Bonferroni-adjusted pairwise comparisons demonstrated significant differences among the groups in dysfunctional attitudes. The control group had significantly higher dysfunctional attitude scores than the MCT group (MD = 23.435, SE = 1.710, $p < .001$) and the

NR group (MD = 39.697, SE = 1.710, $p < .001$), demonstrating the effectiveness of both active interventions relative to the control condition. Furthermore, a statistically significant difference was observed between the MCT and NR groups (MD = 16.262, SE = 1.710, $p < .001$), with the

descriptive pattern indicating a greater reduction in dysfunctional attitudes following Narrative Reconstruction than following Metacognitive Therapy. Regarding grief symptoms, both active treatment groups also differed significantly from the control group. The mean difference between the control and MCT groups was 3.180 ($SE = 0.525$, $p < .001$), while the mean difference between the control and NR groups was 4.179 ($SE = 0.525$, $p < .001$). However, the difference between MCT and NR was not statistically significant ($MD = 0.999$, $SE = 0.525$, $p = .192$). Thus, although both interventions were significantly more effective than the wait-list condition in reducing prolonged grief symptoms, the findings did not provide evidence that either MCT or NR was superior to the other for this outcome. In contrast, Narrative Reconstruction demonstrated significantly greater effectiveness than Metacognitive Therapy in reducing dysfunctional attitudes.

4. Discussion and Conclusion

The present study compared the effectiveness of Metacognitive Therapy (MCT) and Narrative Reconstruction (NR) in reducing dysfunctional attitudes and grief symptoms among women diagnosed with Prolonged Grief Disorder (PGD). The findings demonstrated that both interventions produced significant improvements across the assessment periods, whereas changes in the wait-list control group were comparatively limited. Mixed-design analysis of variance revealed significant time $\times$ group interactions for both dysfunctional attitudes and grief symptoms, indicating that changes across pre-test, post-test, and three-month follow-up differed according to treatment condition. Bonferroni post-hoc analyses further showed that both MCT and NR were significantly more effective than the control condition in reducing dysfunctional attitudes and grief symptoms. However, a differential treatment effect emerged for dysfunctional attitudes: NR produced a significantly greater reduction than MCT. In contrast, although both interventions significantly reduced prolonged grief symptoms compared with the control group, there was no statistically significant difference between MCT and NR on this outcome. Taken together, these findings suggest that the two interventions are both clinically valuable for alleviating the symptomatic burden of PGD, while NR may have a particular advantage when treatment is intended to modify deeper maladaptive cognitive beliefs and assumptions related to the loss.

The first major finding was that MCT significantly reduced grief symptoms compared with the control condition, and this improvement was maintained at the three-month follow-up. This finding is consistent with previous evidence supporting the usefulness of metacognitive interventions for persistent grief. In a pilot randomized controlled trial, MCT was found to be beneficial for individuals experiencing prolonged grief, providing direct evidence that interventions targeting maladaptive metacognitive processes can reduce grief-related distress (Wenn et al., 2019). The present findings also align with research emphasizing the role of rumination, emotion regulation, and coping processes in prolonged grief. Abbasian and Sahragard reported that interventions addressing complicated grief can produce improvements in rumination, emotion regulation, and coping self-efficacy, all of which are closely connected to the mechanisms targeted by MCT (Abbasian & Sahragard, 2024). More broadly, recent evidence indicates that metacognitive techniques are capable of reducing psychological distress in other populations by modifying repetitive cognitive processing and maladaptive relationships with thoughts (Naz et al., 2026; Silva et al., 2026). Thus, the reduction in grief symptoms observed in the MCT group is consistent with a growing body of evidence that psychological symptoms can be alleviated by changing how individuals respond to distressing cognitions rather than necessarily changing the literal content of every thought.

The effectiveness of MCT can be explained through its emphasis on disrupting repetitive and perseverative cognitive processing. Individuals with PGD may repeatedly focus on the circumstances of the death, unanswered questions, perceived responsibilities, lost possibilities, and their continuing emotional pain. Such repetitive thinking may initially be experienced as meaningful or necessary, for example as a means of understanding the loss or preserving a connection with the deceased, but over time it can maintain distress and prevent flexible emotional adaptation. MCT targets beliefs about the usefulness, uncontrollability, and danger of such thinking and teaches individuals to disengage from prolonged rumination through strategies such as detached mindfulness, attentional flexibility, postponement of repetitive thinking, and behavioral testing of metacognitive beliefs. By weakening the tendency to become absorbed in grief-related thoughts, participants may gain greater psychological distance from distressing mental events and increase their ability to shift attention toward current activities and adaptive goals. This interpretation is

compatible with contemporary metacognitive approaches that emphasize changing patterns of mental processing and improving awareness of cognitive and interpersonal states rather than merely challenging thought content (Dimaggio et al., 2025). The broader clinical application of metacognitive principles in complex psychological conditions further suggests that increased flexibility in the processing of internal experiences may promote symptom improvement across diverse forms of psychopathology (Fioravanti et al., 2026).

The second major finding was that NR significantly reduced prolonged grief symptoms compared with the wait-list control condition. This result is strongly supported by previous research examining narrative-based treatments for persistent grief. Narrative Reconstruction Therapy has shown promising results in individuals with PGD, with a pilot investigation demonstrating improvements following a structured reconstruction of the loss narrative (Elinger et al., 2021). A subsequent quasi-experimental trial similarly reported symptomatic improvement and enhanced memory integration following narrative reconstruction, providing particularly relevant support for the present findings (Elinger et al., 2023). Narrative therapy has also been reported to be beneficial for individuals experiencing prolonged grief, suggesting that the reconstruction of personal stories surrounding bereavement can facilitate emotional adaptation (Babar et al., 2024). In addition, a systematic review focused on narrative approaches to complicated grief highlighted their theoretical and clinical utility for addressing unresolved bereavement, identity disruption, and difficulty integrating loss (Santos & Soares, 2024). Accordingly, the current results add to evidence indicating that structured engagement with the story and meaning of a loss can reduce persistent grief-related suffering.

The therapeutic effect of NR on grief symptoms may be understood through the role of autobiographical integration and meaning-making in adaptation to bereavement. PGD is characterized not merely by the continued presence of sadness but by difficulty incorporating the reality and implications of the death into an ongoing sense of self and life. The bereaved person may retain fragmented, emotionally overwhelming, or insufficiently processed memories that remain disconnected from the broader autobiographical narrative. Narrative reconstruction repeatedly and systematically engages with the loss-related memory, enabling the individual to organize what happened, identify previously avoided aspects of the experience, clarify emotional and cognitive responses, and place the event

within a coherent temporal and personal framework. Evidence emphasizing the importance of meaning reconstruction in grief supports this explanation. The Grief and Meaning Reconstruction Inventory reflects the significance of meaning-related processes in understanding adaptation to loss (Soraci et al., 2025), while clinical work involving meaning-centered grief interventions has shown that structured exploration of loss and meaning can contribute to psychological improvement (Batista et al., 2024). Therapeutic writing following early pregnancy loss has similarly highlighted the potential value of narrative processing for grief-related well-being (de Paiva et al., 2025). These findings suggest that transforming an emotionally fragmented experience into an organized and meaningful personal narrative may reduce the unresolved quality of grief and allow the loss to become integrated into continuing life.

The absence of a statistically significant difference between MCT and NR in reducing grief symptoms is also theoretically meaningful. Although the two therapies employ different strategies, they may converge on a common clinical outcome through distinct pathways. MCT primarily modifies the individual's relationship with grief-related cognition by reducing rumination, threat monitoring, and beliefs regarding uncontrollability, whereas NR primarily reorganizes the autobiographical representation and meaning of the loss. Both processes can lessen the extent to which grief dominates mental life and interferes with psychological functioning. This convergence may explain why both treatments produced substantial reductions in grief symptoms despite differing in their theoretical emphases. The broader psychotherapy literature on PGD indicates that several forms of targeted psychological treatment can yield significant symptom reduction, suggesting that more than one pathway may promote adaptation to bereavement (Srivastava et al., 2025). Similarly, improvements in PGD have been reported following Acceptance and Commitment Therapy through changes in emotion regulation, self-compassion, and cognitive fusion (Daraei et al., 2025), while narrative exposure approaches have demonstrated benefits for resilience, mindfulness, and quality of life (Rezaei Shahi et al., 2025). These findings reinforce the possibility that successful PGD treatment can be achieved through different therapeutic mechanisms provided that the intervention disrupts processes maintaining persistent attachment-related distress and facilitates renewed psychological engagement with life.

The most distinctive finding of the present study was that NR was significantly more effective than MCT in reducing dysfunctional attitudes. Although both interventions produced significant improvements relative to the control group, the magnitude of reduction was greater in the NR condition and continued to develop through follow-up. This result may be explained by differences in the primary cognitive targets of the two approaches. Dysfunctional attitudes involve relatively enduring assumptions about the self, relationships, achievement, dependence, vulnerability, acceptance, and control. Previous research has shown that these cognitive structures can be modified through psychological intervention and that reductions in dysfunctional attitudes accompany improvements in emotional functioning (Ebrahimi et al., 2013). Research among women experiencing psychological distress has likewise demonstrated the modifiability of dysfunctional attitudes through structured psychological intervention (Fahami & Abed, 2026). The current results extend these observations to women with PGD and suggest that narrative reconstruction may be particularly suited to modifying maladaptive beliefs that are embedded within the personal meaning of a major loss.

NR may have demonstrated superiority because it directly engages with the semantic and autobiographical content from which dysfunctional attitudes emerge. Following bereavement, an individual may develop or reinforce global beliefs such as “I cannot function without this person,” “my life has permanently lost its meaning,” “I failed the deceased,” or “there is no future in which I can be secure or fulfilled.” Such beliefs are not isolated thoughts; they can become incorporated into broader personal narratives regarding identity, responsibility, attachment, worth, and the future. Narrative reconstruction requires participants to revisit the loss experience in detail, organize its sequence, identify missing or avoided elements, and reconsider its meaning within the context of the broader life story. Through this process, rigid interpretations can be revised as the individual develops a more integrated account of the event. This interpretation is consistent with evidence that narrative reconstruction can improve the integration of loss-related memories (Elinger et al., 2023) and with findings indicating that narrative methods can influence emotional and cognitive adaptation to bereavement (Nelson et al., 2022). Strength-based narrative therapy has also been associated with improvements in depression and quality of life, suggesting that narrative restructuring can influence broader self-evaluative and emotional processes (Zhu et al., 2025).

In contrast, the relatively smaller effect of MCT on dysfunctional attitudes should not be interpreted as evidence that it is ineffective for maladaptive cognition. MCT significantly reduced dysfunctional attitudes compared with the control group, indicating that modifying metacognitive processes may indirectly weaken dysfunctional beliefs. When individuals disengage from repetitive negative thinking and cease treating every distressing cognition as significant, uncontrollable, or dangerous, rigid cognitive assumptions may become less emotionally dominant and less frequently reinforced. However, MCT generally places greater emphasis on changing the process of thinking than on directly restructuring the semantic content of core assumptions. Consequently, beliefs about personal worth, dependency, vulnerability, or the meaning of the loss may remain less directly addressed than in a narrative intervention specifically designed to reconstruct meaning. This distinction may explain why MCT was effective but comparatively less powerful than NR for dysfunctional attitudes. The finding is also consistent with evidence that metacognitive approaches are effective across disorders primarily through alterations in cognitive processing, self-monitoring, and the regulation of attention (Naz et al., 2026; Silva et al., 2026), rather than through direct restructuring of every underlying belief.

The persistence of improvement through the three-month follow-up further strengthens the clinical relevance of both interventions. The descriptive pattern showed continued or sustained reductions in dysfunctional attitudes and grief symptoms after termination of treatment, particularly in the two experimental groups. Maintenance of change is especially important in PGD because the disorder is defined by persistence and because exposure to anniversaries, reminders, interpersonal changes, and continuing life transitions can reactivate grief-related distress. The continued improvement observed after treatment may indicate that participants acquired processes that remained active beyond the therapeutic sessions. MCT may have provided strategies for independently disengaging from rumination and maladaptive metacognitive control, whereas NR may have resulted in a reorganized loss narrative that continued to influence cognitive and emotional processing after therapy ended. This interpretation is compatible with the contemporary view of grief adaptation as an ongoing process through which the mind and brain gradually accommodate the changed reality created by loss (O'Connor, 2019). It is also consistent with the conceptualization of PGD as a measurable clinical syndrome in which sustained

changes in core symptoms are essential indicators of meaningful treatment response (Prigerson et al., 2021).

Several limitations should be considered when interpreting the present findings. First, the sample consisted exclusively of 45 women attending psychological clinics in Western Tehran, which limits the generalizability of the results to men, individuals who do not seek psychological services, and populations from other cultural, socioeconomic, and geographic backgrounds. Second, participants were recruited through purposive sampling, which may have introduced selection bias despite subsequent allocation to the study conditions. Third, the relatively small number of participants in each group may have limited statistical power for detecting more subtle differences between the two active interventions, particularly for grief symptoms. Fourth, both primary outcomes were assessed using self-report measures, making the findings potentially susceptible to response tendencies, recall bias, and socially desirable responding. Fifth, the follow-up period was limited to three months, and therefore the longer-term stability of treatment gains cannot be established. Finally, the study did not systematically examine potential mechanisms or moderators of treatment response, such as baseline rumination, loss circumstances, relationship to the deceased, attachment characteristics, severity of dysfunctional attitudes, treatment adherence, or participants' expectations regarding therapy.

Future studies should replicate these findings using larger and more heterogeneous samples that include both women and men, participants from different age groups, and individuals representing diverse socioeconomic, cultural, and geographical contexts. Multicenter trials would be particularly valuable for improving external validity. Researchers should also incorporate longer follow-up periods, such as six months, one year, or longer, to determine whether therapeutic gains remain stable and whether differences between MCT and NR emerge over time. Future investigations could combine self-report measures with structured clinical interviews, behavioral indicators, clinician ratings, and other objective or multi-informant assessments. It would also be useful to examine mediators of change to determine whether reductions in rumination and maladaptive metacognitive beliefs account for improvement following MCT, while enhanced autobiographical integration and meaning reconstruction mediate the effects of NR. Moderator analyses could identify which patients are most likely to benefit from each intervention based on cognitive profile, severity of grief, type of loss, attachment

patterns, degree of narrative fragmentation, or baseline dysfunctional attitudes. Comparative studies involving additional evidence-based interventions and dismantling designs examining specific therapeutic components would further clarify the active mechanisms responsible for clinical improvement.

The findings have several implications for clinical practice with women experiencing PGD. Clinicians may consider both MCT and NR as viable approaches for reducing persistent grief symptoms, with treatment selection guided by the dominant psychological mechanisms identified during assessment. MCT may be particularly appropriate when a patient presents with intense rumination, repetitive analysis of the death, persistent threat monitoring, beliefs that grief-related thoughts are uncontrollable, or maladaptive attempts to suppress or manage cognition. NR may be especially useful when grief is accompanied by rigid dysfunctional beliefs, fragmented or disorganized memories of the loss, disruption of identity, persistent self-blame, or an inability to construct a meaningful account of life after bereavement. The greater reduction in dysfunctional attitudes following NR suggests that clinicians should give particular consideration to narrative methods when maladaptive schemas and loss-related meanings constitute central treatment targets. In routine practice, assessment of both grief severity and cognitive mechanisms may facilitate a more individualized, mechanism-based approach in which intervention strategies are matched to the patient's primary maintaining processes rather than applying a uniform therapeutic model to all individuals with prolonged grief.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Acknowledgments

We hereby thank all individuals for participating and cooperating us in this study.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

References

- Abbasian, M., & Sahragard, M. (2024). The Effectiveness of Complicated Greif Treatment on Rumination, Emotion Regulation and Coping Self-Efficacy in People with Prolonged Grief Disorder. *International Journal of Applied Behavioral Sciences*, 11(2), 8-20.
- Babar, A., Nosheen, N., & Ahsan, L. (2024). Exploring the Effectiveness of Narrative Therapy Among Prolonged Grief Disorder. *Journal of Asian Development Studies*, 13(4), 66-81. <https://doi.org/10.62345/jads.2024.13.4.5>
- Batista, J., Alves, D., Pires, N., Silva, J. R., Mendes, I., Magalhães, C., & Neimeyer, R. A. (2024). The Meaning in Loss Protocol: A Clinical Trial of Online Grief Therapy. *Death Studies*, 49(1), 8-20. <https://doi.org/10.1080/07481187.2024.2370633>
- Daraei, M., Noruzi, A., & Hosseini Tabaghdehi, L. (2025). The Effectiveness of Acceptance and Commitment Therapy on Emotion Regulation, Self-Compassion, and Cognitive Fusion in Individuals with Prolonged Grief Disorder. *Sadra Medical Journal*, 13(4), 795-809. <https://doi.org/10.30476/smsj.2025.103075.1544>
- de Paiva, T. C., Faria, A. L., & Soares, L. (2025). Therapeutic Writing and the Grieving Process of Mothers Who Experienced Early Pregnancy Loss-Narrative Well-Being. *Journal of Poetry Therapy*, 38(2), 88-114. <https://doi.org/10.1080/08893675.2024.2376105>
- Dimaggio, G., Centonze, A., Ottavi, P., & Popolo, R. (2025). *Experiential Techniques in Metacognitive Interpersonal Therapy with Personality Disorders: The Therapeutic Relationship*. Taylor & Francis. <https://doi.org/10.4324/9781003570967>
- Ebrahimi, A., Neshatdoost, H. T., Mousavi, S. G., Asadollahi, G. A., & Nasiri, H. (2013). Controlled Randomized Clinical Trial of Spirituality Integrated Psychotherapy, Cognitive-Behavioral Therapy and Medication Intervention on Depressive Symptoms and Dysfunctional Attitudes in Patients with Dysthymic Disorder. *Advanced Biomedical Research*, 2, 53. <https://doi.org/10.4103/2277-9175.114201>
- Elinger, G., Hasson-Ohayon, I., Bar-Shachar, Y., & Peri, T. (2023). A Quasi-Experimental Trial of Narrative Reconstruction for Prolonged Grief Disorder: Symptomatic Improvement and Enhanced Memory Integration. *Journal of Clinical Psychology*, 79, 2849-2868. <https://doi.org/10.1002/jclp.23583>
- Elinger, G., Hasson-Ohayon, I., Barkalifa, E., Boelen, P. A., & Peri, T. (2021). Narrative Reconstruction Therapy for Prolonged Grief Disorder-A Pilot Study. *European Journal of Psychotraumatology*, 12(1), 1896126. <https://doi.org/10.1080/2008198.2021.1896126>
- Fahami, Z., & Abed, M. (2026). Self-Compassion Training for Dysfunctional Attitudes, Perceived Stress, and Marital Adjustment of Married Women with Depression. *Counseling Outcome Research and Evaluation*, 1-21. <https://doi.org/10.1080/21501378.2026.2687457>
- Fioravanti, G., MacBeth, A., Nicolis, M., Gala, E., & Dimaggio, G. (2026). Metacognitive Interpersonal Therapy-Eating Disorders (MIT-ED) in the Case of an 18-Year-Old Girl With Avoidant and Obsessive-Compulsive Personality Disorders, Binge Eating Disorder and Obesity. *Journal of Clinical Psychology*, 82(3), 414-423. <https://doi.org/10.1002/jclp.70064>
- Naz, M., Asghar, A., Mujitaba, A., & Shakoor, S. (2026). Evaluating the Effectiveness of Metacognitive Techniques in Reducing Body Dissatisfaction Among Pakistani Young Adults: A Pilot Randomized Controlled Trial. *Regional Lens*, 5(1), 166-178. <https://doi.org/10.55737/rl.v5i1.26179>
- Nelson, K., Lukawiecki, J., Waitschies, K., Jackson, E., & Zivot, C. (2022). Exploring the Impacts of an Art and Narrative Therapy Program on Participants' Grief and Bereavement Experiences. *OMEGA - Journal of Death and Dying*, 90(2), 726-745. <https://doi.org/10.1177/0030222822111726>
- O'Connor, M. F. (2019). Grief: A Brief History of Research on How Body, Mind, and Brain Adapt. *Biopsychosocial Science and Medicine*, 81(8), 731-738. <https://doi.org/10.1097/PSY.0000000000000717>
- Prigerson, H. G., Boelen, P. A., Xu, J., Smith, K. V., & Maciejewski, P. K. (2021). Validation of the New DSM-5-TR Criteria for Prolonged Grief Disorder and the PG-13-Revised (PG-13-R) Scale. *World Psychiatry*, 20(1), 96-106. <https://doi.org/10.1002/wps.20823>
- Rezaei Shahi, F., Shaeiri, M. R., & Sarichloo, M. E. (2025). The Effectiveness of Narrative Exposure Therapy on Resilience, Mindfulness, and Quality of Life in Individuals with Prolonged Grief Disorder. *Journal of Psychological Science*, 24, 221-241.
- Santos, P., & Soares, L. (2024). Theoretical-Practical Guidelines for Mental Health Professionals on Complicated Grief: A Systematic Review Based on Narrative Therapy. *Psychology and Behavioral Science International Journal*, 22(1), 556080. <https://doi.org/10.19080/PBSIJ.2024.22.556080>
- Silva, C., Alves, E., Schneider, B. C., Sampaio, F., Morgado, B., Santos, B. M., & Pinho, L. (2026). Metacognitive Training (MCT-Silver) for Older Adults with Depressive Symptoms in Portugal: A Pilot Study. *Cognitive therapy and research*, 1-21. <https://doi.org/10.1007/s10608-026-10767-6>
- Soraci, P., Moriconi, V., Moggia, D., Melchiori, F. M., Di Bernardo, C., Orati, L., Chini, E., Guaitoli, E., Tiozzo, R., Rossi, A., & Spagna, S. (2025). Italian Grief and Meaning Reconstruction Inventory (GMRI): Exploratory, Confirmatory and Network Analyses. *Journal of Loss and Trauma*, 30(1), 58-82. <https://doi.org/10.1080/15325024.2024.2357785>
- Srivastava, T., Lee, K., Ehrenkranz, R., Cozzolino, P. J., Wise, F. A., Burns, M., & Penberthy, J. K. (2025). The Efficacy of Psychotherapeutic Interventions for Prolonged Grief Disorder: A Systematic Review. *Journal of affective disorders*, 380, 561-575. <https://doi.org/10.1016/j.jad.2025.03.173>
- Wenn, J. A., O'Connor, M., Kane, R. T., Rees, C. S., & Breen, L. J. (2019). A Pilot Randomised Controlled Trial of Metacognitive Therapy for Prolonged Grief. *BMJ open*, 9(1), e021409. <https://doi.org/10.1136/bmjopen-2017-021409>



Zhu, S., Liao, Q., & Yuan, H. (2025). Effect of Strength-Based Narrative Therapy on Depression Symptoms and Quality of Life in the Elderly. *Iranian Journal of Public Health*, 54(1), 124-132. <https://doi.org/10.18502/ijph.v54i1.17582>

