Mindful
Continuing Education

Understanding Grief and Loss: Assessment, Intervention, and Professional Resilience



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Section 1: Introduction

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Defining Grief and Loss

Loss is a universal human experience, yet every person's grief journey is unique. The Merriam-Webster Dictionary (n.d.) defines the term loss in several different ways, including "the act or fact of being unable to keep or maintain something or someone; the partial or complete deterioration or absence of a physical capability or function; an instance of losing someone or something; the harm or privation resulting from losing or being separated from someone or something; and a failure to gain, win, obtain, or utilize" (para. 1-5).

The American Psychological Association (2018) defines grief as "an anguish experienced after a significant loss, usually the death of a beloved person. Grief is often distinguished from bereavement and mourning. Not all bereavements result in a strong grief response, and not all grief is given public expression. Grief often includes physiological distress, separation anxiety, confusion, yearning, obsessive dwelling on the past, and apprehension about the future. Grief may also take the form of regret for something lost, remorse for something done, or sorrow for a mishap to oneself" (para. 1).

Russell Friedman, a co-founder of the Grief Recovery Institute, has defined grief as "the normal and natural emotional reaction to loss or change of any kind. Of itself, grief is neither a pathological condition nor a personality disorder" (Friedman, 2019, para. 3). Grief can also be thought of as "the conflicting feelings caused by the end of or a change in a familiar pattern of behavior" (Friedman, 2019, para. 5).

Grief and Loss - Death and Other Experiences

It is most common to associate the concepts of grief and loss with death. This type of loss can involve several layers of grief.

- First, when someone dies, grieving the person themself happens, regardless of the relationship of the bereaved to the deceased. Many different feelings can accompany loss through a death, and it is normal to grieve the death on a timeline of past, present, and future.
    - In terms of the past, memories may flood in or be difficult to access. A bereaved person may think about things they should have done differently or mistakes they made that they can no longer correct.
    - In the present, a bereaved person may grieve the deceased's absence and struggle to adapt to the changes in their life.
    - Equally important, a bereaved person grieves the future they will never have with the deceased and the things that the deceased will miss out on in life.
- Next, when someone dies, it is natural to grieve for oneself, including the impact the deceased made on their life, changes in identity, roles, and perspectives, and the need to confront one's mortality.
- Furthermore, when someone dies, grieving the aspects of day-to-day life may happen. For example, life as a bereaved person may be completely different after death, so there is a process of grieving the life they had before while navigating life as it is now.
- Lastly, depending on the type of loss, a bereaved person's worldview may change, and they may need to reorient themself and reconstruct their life (Haley, 2022).

In addition to death, many different types of losses happen throughout the lifespan that can lead to experiencing grief. One type of loss is related to identity, role, or affiliation. When someone loses their identity, they mourn a loss of their sense of self. They grieve who they thought they were and eventually create a new story or identity that integrates their loss into their personal narrative. Sometimes this type of loss is within someone's control; other times, it is not. Some examples of this type of loss include being diagnosed with an illness, going through a divorce, children growing up and leaving home, losing a job or switching careers, and leaving a community.

Another type of loss is the loss of safety, which affects physical, emotional, and mental well-being. When a person has specific experiences that cause them to lose their sense of safety, their world becomes unsafe, and they may start to experience symptoms of post-traumatic stress disorder, such as hypervigilance or numbness. It can also be difficult for a person to regain a sense of safety even when their situation stabilizes. A few examples of this type of loss include being a survivor of physical, emotional, or sexual trauma, being a child of a divorce, having unstable housing, living in a community with exposure to violence, and discovering betrayal in a relationship, such as infidelity.

Loss of autonomy is another type of loss that may occur in a person's lifetime. When people lose their autonomy, they can lose their ability to manage their bodies and lives, resulting in grief over a loss of a sense of control and difficulty maintaining a sense of self. In these situations, a person often grieves and reexamines who they are in light of their limitations. Some examples of this type of loss include an older adult who is no longer able to be independent in caring for themselves, a person with an illness that causes them to lose physical and cognitive abilities, and a person who is experiencing financial difficulties and needs to rely on others for help.

A person may also experience a loss of hope, dreams, and expectations for their life. When life does not unfold as a person expects, they may feel it is unfair and develop a deep sense of grief over how they thought their life would unfold versus their current reality. A few examples of this type of loss include struggling with infertility, difficulty finding an expected career path or place of belonging in the world, and losing a community because of unexpected political shifts (Epstein, 2026).

Course Summary

While it is difficult to estimate its prevalence, one could estimate that nearly 100% of people experience some type of loss in their life that is accompanied by feelings of grief. Because of this reality, mental health professionals must possess the knowledge and skills necessary to recognize, assess, and effectively support individuals experiencing various forms of grief. This course provides an in-depth exploration of the grieving process, including normal grief, complicated grief, disenfranchised grief, sudden and traumatic loss, and ambiguous loss.

Participants will examine the emotional, cognitive, behavioral, physical, and spiritual impacts of grief while gaining an understanding of leading grief theories and contemporary perspectives on bereavement. Participants will explore evidence-informed assessment strategies and therapeutic interventions to enhance clinical effectiveness when working with grieving individuals, families, and communities.

This course also addresses the personal and professional impact of grief exposure on helping professionals. Participants will learn practical strategies for self-awareness, self-care, compassion fatigue prevention, and ethical practice to ensure they can provide effective support while maintaining their own well-being.

Section 1 Key Terms

Loss - defined in several ways, including “the act or fact of being unable to keep or maintain something or someone; the partial or complete deterioration or absence of a physical capability or function; an instance of losing someone or something; the harm or privation resulting from losing or being separated from someone or something; and a failure to gain, win, obtain, or utilize” (Merriam-Webster Dictionary, n.d., para. 1-5).

Grief - defined as “an anguish experienced after a significant loss, usually the death of a beloved person. Grief is often distinguished from bereavement and mourning. Not all bereavements result in a strong grief response, and not all grief is given public expression. Grief often includes physiological distress, separation anxiety, confusion, yearning, obsessive dwelling on the past, and apprehension about the future. Grief may also take the form of regret for something lost, remorse for something done, or sorrow for a mishap to oneself” (American Psychological Association, 2018, para. 1). Another definition of grief is “the normal and natural emotional reaction to loss or change of any kind. Of itself, grief is neither a pathological condition nor a personality disorder” (Friedman, 2019, para. 3). Grief can also be thought of as “the conflicting feelings caused by the end of or a change in a familiar pattern of behavior” (Friedman, 2019, para. 5).

Section 2: Types of Grief and Loss Experiences and Their Impact Across the Lifespan

References: 1, 3, 4, 6, 7, 8, 15, 17, 21, 26, 28, 29, 31, 33, 35, 38, 39, 44, 45, 50, 56

Several different types of grief and loss can exist across a person’s lifespan. When thinking about grief, remember that it is not a single emotion. Grief is an experience after a meaningful loss that affects how a person feels physically,

mentally, emotionally, behaviorally, and/or spiritually (Morrow, 2026). This section will review different types of grief, including normal grief, complicated grief, disenfranchised grief, ambiguous loss, and sudden and traumatic loss.

Normal Grief

Normal grief, which may also be called uncomplicated grief, is “a natural response to loss, with common emotions experienced by most people” (Morrow, 2026, para. 7). It can be thought of as a process that encompasses many different physical sensations, emotions, behaviors, and cognitions that can appear and reappear at different points (Worden, 2009).

Physical Sensations

According to Worden (2009), physical sensations are often overlooked in the grieving process, but they play a significant role in it (p. 23). The following are common physical symptoms of grief:

- Headaches
- Oversensitivity to noise
- Dry mouth
- Throat or chest tightness
- Heart palpitations
- Shortness of breath
- Nausea or upset stomach
- Muscle weakness
- Joint pain

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- Restlessness
- Fatigue
- Weakened immune system (Cleveland Clinic, 2023b; Worden, 2009)

Emotions

The common emotions that accompany normal grief include sadness, anger, guilt, anxiety, loneliness, fatigue, helplessness, shock, yearning, relief, and numbness. These emotions are often fluid, and people may experience many of them at one time.

- Sadness is the most common emotion found in bereaved people experiencing normal grief. It often manifests as crying or sobbing (Worden, 2009).
- Anger is a frequent emotion that is experienced by someone who is grieving. It can be confusing at times. It may also be a protective emotion that is covering up another painful one. A person may direct their anger to different places, including at themselves, the person who died, the circumstances around the death, or even at God or a different higher power. Anger is often displaced, or directed at other people.
    - Anger with oneself can be associated with guilt and thoughts related to what the bereaved "should" have done.
    - Anger at the person who died could be because they left, made certain choices, or left things unsaid.
    - Anger at the circumstances around the death could be related to the death being unfair or things happening that were outside of one's control, such as being diagnosed with a terminal illness.

    - Anger at God or a higher power could be related to the idea that something or someone allowed death to happen (Worden, 2009; Linnemann, 2026).

- Guilt has been noted to possibly be the most painful companion to grief by Elizabeth Kübler-Ross. At times, a bereaved person may think that they could have done something to prevent the loss and that they are responsible for it. Other times, a person may experience survivor's guilt, which includes remorse over surviving someone else's loss, wondering why they survived, and how others may feel about it. Guilt may also happen when a bereaved person does not believe that they paid enough attention to, cared well enough for, or deserved love from the person who died (Prest, 2024).

- Anxiety primarily comes from two different sources. Oftentimes, strong intensity and longer persistence of the following feelings indicate an abnormal grief reaction.

    - First, the bereaved may feel fearful that they will not be able to take care of themself without the deceased.

    - Second, the bereaved may also feel a heightened sense of their own mortality after the death of someone in their life. Feelings of anxiety can range from slight insecurity to having panic attacks.

- Helplessness is closely related to anxiety and may be experienced in the early stages after a loss. A bereaved person may feel helpless because they cannot fix the situation they are experiencing after the loss. Their self-confidence may be impacted, especially if they feel they cannot move forward and take care of themself and/or their family after the loss. A bereaved person may also feel helpless if they cannot ease someone else's

pain (e.g., a spouse who is taking care of a child and comforting them after the death of their partner and parent to the child).

- Loneliness is a common emotion that is felt by a bereaved person, especially in those who have lost someone they were very close to and had a daily relationship with.
- Shock occurs most often when a person dies suddenly. It can also occur even when a death is expected, as a bereaved person may have a difficult time believing their loved one is gone (Worden, 2009).
- Yearning after a loss is often connected to desiring the person, the relationship, places, things, or moments that were treasured and are now gone. A bereaved person experiencing yearning is acutely aware of the void in their life after the loss, and they may be preoccupied with trying to stay connected to it. Yearning also involves grieving the loss of a future that is no longer possible (Haley, 2017).
- Relief is often experienced after the death of a loved one who was living with a long and/or painful illness. The bereaved person likely witnessed the suffering that their loved one endured, and they may feel relieved that they are no longer suffering. Relief can also happen when a bereaved person had a difficult, often lifelong, relationship with the deceased.
- Numbness most often happens immediately following a loss. It likely occurs because there are so many emotions to deal with at once, which can be overwhelming, so instead numbness can serve as a way to protect the bereaved person (Worden, 2009).

Behaviors

The following are common behaviors that people who are experiencing normal grief report after a loss:

- Trouble sleeping, including difficulty falling asleep or waking up early in the morning
- Eating more or less than normal
    - Eating less is more common and can lead to weight loss
- Doing absentminded things or behaviors that cause inconvenience or harm
- Withdrawing socially, which can include from relationships and an interest in the world
- Dreaming of the deceased, including normal dreams and distressing ones
- Avoiding reminders of the deceased or quickly getting rid of their belongings, often to minimize emotional pain
- Visiting places and/or carrying objects that are a reminder of the deceased
- Treasuring objects that belonged to the deceased
- Searching and calling out for the deceased
- Acting restless and hyperactive to try to get some relief
- Crying (Worden, 2009)

According to Worden (2009), these behaviors typically correct themselves over time. If they persist, they could indicate more complicated grief.

Cognitions

Many different thought patterns are common during normal grief and typically resolve over time. These thought patterns can include:

- Confusion, including having difficulty ordering thoughts
- Trouble with concentration and memory
- Issues making decisions and problem-solving
- Disbelief
- Preoccupations, ruminations, or obsessions with the deceased
- Auditory and visual hallucinations (Cleveland Clinic, 2023b; Worden, 2009)

Spirituality

Spirituality is another component of the grief process that may be impacted after a loss. In some situations, grief may lead a person to question their belief in God or another higher power. They may wonder why the loss happened and what it means for their faith and greater purpose in life. In other cases, people may feel closer to God or another higher power and find comfort in their faith when dealing with a loss. They may also feel closer to the person who died if they believe they will be reunited with them in the afterlife (Larsen, 2023).

More About Normal Grief

The process of normal grief moves forward and changes over the days, weeks, months, and years after the loss (Morrow, 2026). While there is no exact structure or timeline, a person experiencing normal grief typically adapts and establishes a new normal over time, and grief becomes integrated into their life. For example, a person may not forget the loss entirely, but they learn to cope with it and

eventually find meaning and joy in their life. They may also continue to long for the person who died, but this becomes less persistent, and they find ways to honor a connection with them (Association for Behavioral and Cognitive Therapies, 2021; Morrow, 2026; Starkman, 2024).

According to the Association for Behavioral and Cognitive Therapies (2021), "successful adaptation requires understanding the finality and consequences of the loss, revisiting future hopes and plans, and redefining the relationship with the deceased. Additionally, positive emotions, self-compassion, and social support support adaptation to loss. Even with successful adaptation, intensity of grief may wax and wane" (p. 1). For example, a person may experience more intense feelings around anniversaries or holidays. However, as the grief is integrated into their lives, these feelings become shorter and less intense.

Complicated Grief

As stated by the Mayo Clinic (2022), "complicated grief is like being in an ongoing, heightened state of mourning that keeps you from healing" (para. 6). Complicated grief is estimated to affect about 10% of bereaved people, which is millions of people in the U.S. alone. It can occur after the loss of any close relationship, such as a romantic partner or a parent losing a child.

The risk factors for complicated grief include:

- Being female
- Older age
- History of mood or anxiety disorders, including depression, separation anxiety, or post-traumatic stress disorder
- Substance abuse, including alcohol or drugs

- Suicidal ideation
- Multiple losses
- Trauma exposure
- Anxious attachment style
- Dependence on the deceased
- Depression while being a caregiver to a loved one with a terminal illness
- Depression in early bereavement
- An unexpected or violent death (e.g., a car accident, murder, or suicide)
- Death of a child
- Limited or inadequate social supports after the death
- Lower socioeconomic status
- Significant financial issues after the death

In contrast to normal grief, complicated grief results when the process of adapting to the loss lingers, slows, or experiences complications, and a person has ongoing symptoms (as noted below). This type of grief can be considered when the intensity of grief is not decreasing in the months following the loss, considering what is expected based on a person's social, cultural, or religious norms.

Symptoms of complicated grief look similar to those of normal grief during the first few months after a loss. However, with complicated grief, the following symptoms persist or get worse:

- Intense emotional pain and sorrow related to the loss

- Overwhelming, intrusive thoughts or ruminations related to the circumstances or consequences of the loss, including thoughts about what might have been done differently
- Difficulty focusing on things other than the loss
- Extreme focus on reminders that keep the loss present in the bereaved person's life, or excessive avoidance of reminders
- Trouble regulating emotions
- Ongoing and intense longing
- Difficulty accepting the loss
- Numbness, detachment, or bitterness
- Feeling that life no longer has meaning or purpose
- Challenges trusting other people
- Inability to enjoy life or think back to positive experiences that happened before the loss
- Developing problems, such as addictions, or exacerbating existing conditions (American Psychiatric Association, 2025; Association for Behavioral and Cognitive Therapies, 2021; Cleveland Clinic, 2023a; Mayo Clinic, 2022)
- A spiritual crisis, which may look like losing faith or feeling that they are being punished or betrayed by God or a higher power, and/or assuming their failure with God or a higher power led to a loved one's death (Mendoza, 2020).

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Additionally, complicated grief can cause suicidal thoughts, trouble sleeping, stress, loss of appetite, and declining physical health (Cleveland Clinic, 2023a).

Complicated grief impairs a person's daily functioning and their ability to resume their normal life and routines. They may have difficulty fulfilling their responsibilities. It can also cause a person to withdraw from others and any social activities, causing issues in interpersonal relationships. Complicated grief may also be indicated if a person is experiencing deep sadness, guilt, or self-blame, including believing that they did something wrong or could have prevented the loss. Additionally, if a bereaved person feels that life is not worth living without the loved one who died or if they wish they would have died with their loved one, complicated grief may also be present (Mayo Clinic, 2022).

Complicated grief is also known as prolonged grief disorder, which was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5-TR in 2022 (American Psychiatric Association, 2025). To be diagnosed with a prolonged grief disorder, a person must meet the following six criteria:

- A death of a person who was close to the bereaved occurred at least 12 months ago for adults and at least six months ago for children.
- The grief response must include one or both of the following nearly every day for at least the last month:
    - Intense yearning or longing for the deceased
    - Preoccupation with thoughts or memories of the deceased
        - In children and adolescents, preoccupation is often focused on the circumstances of the death
- Three of the following eight symptoms must have been experienced nearly every day for at least the last month:

    - Disruption in one's identity (e.g., feeling as if a part of oneself died when the other person died)
    - Sense of disbelief about the death
    - Avoidance of reminders that the person is deceased
    - Intense emotional pain connected to the death (e.g., anger, bitterness, sorrow)
    - Difficulty reintegrating into various aspects of life (e.g., social relationships, interests, future planning)
    - Emotional numbness that has resulted from the death
    - Limited sense of meaning and purpose as a result of the death
    - Intense loneliness as a result of the death
- The loss must also cause significant distress or impairment in important areas of functioning in a person's life.
- The duration and severity of the bereaved person's reaction exceeds expected norms based on the individual's culture and context.
- The symptoms are not better explained by major depressive disorder, post-traumatic stress disorder, or another mental health disorder, or the physiological effects of a substance or other medical condition (American Psychiatric Association, 2025; Heid & Young, 2022).

As stated by Shear (as cited in Heid & Young, 2022), "complicated grief or prolonged grief disorder is by and large defined by the extent to which grief affects someone's life. It is when grief is continuing to dominate someone's life, getting other people frustrated, and it feels like they cannot come to terms with the new reality or restore their ability to thrive" (para. 16).

Disenfranchised Grief

Every society has norms and expectations about how a person grieves, how long grief should last, and whom and what can be grieved. As long as a person stays within these norms, they can expect support and recognition. Whether a loss is acknowledged affects how a person grieves (Doka, 2016). Disenfranchised grief, a term coined by Dr. Kenneth Doka, can occur when a "loss is unrecognized by others and perhaps not openly acknowledged, publicly mourned, or socially sanctioned" (Doka, 2016, p. 56). Some situations in which this type of grief can occur are when a partner from an extramarital affair dies, when an ex-spouse or ex-partner dies, or when someone has a death by suicide, homicide, or a drug overdose. Some other examples of disenfranchised grief include having a miscarriage, the death of a sibling in adulthood, job loss, the loss of a pet, giving a child up for adoption, and losing a person who was elderly. In these instances, a person may carry shame or stigma related to the loss (Doka, 2016; Kennedy, 2021).

According to Doka (2016), "persons with disenfranchised grief frequently suffer in silence, not knowing the true cause of their reactions, having no context in which to understand them, and receiving little support or recognition" (p. 183). People experiencing disenfranchised grief may be less open to sharing their grief with others. They may also feel that they do not have a right to grieve because these types of losses are viewed as less acceptable in society (Doka, 2016). This can lead to feelings of intense isolation and loneliness. A bereaved person with disenfranchised grief may also feel shame, guilt, or like something is wrong with them for grieving for a period of time. They may also feel angry at both the loss and others who do not understand it and/or their grief. Furthermore, they may have difficulty asking for help, withdraw from relationships, and have symptoms of anxiety or depression that linger well past the loss (Linnemann, n.d.).

As a result of these experiences, people may have significant challenges moving through the grieving process, which causes their grief to be persistent (Doka, 2016). Research has shown that disenfranchised grief is associated with a higher risk of prolonged grief disorder, depression, and post-traumatic stress disorder (Linnemann, n.d.). As stated by Linnemann (n.d.), “What makes disenfranchised grief especially painful is that it adds an extra layer on top of the grief itself. You are not just grieving your loss—you are also grieving the support you never received, and struggling with the message that your pain does not matter. That is an enormous weight to carry alone” (para. 23).

Ambiguous Loss

Ambiguous loss is a term that Dr. Pauline Boss coined in the 1970s. It is the grief and emotional pain that happens when a person experiences a loss in their life, and they do not have the opportunity for closure or resolution. Ambiguous loss brings uncertainty, and closure is either delayed or may never happen, which makes it more difficult to deal with compared to losing someone to death. Another reason ambiguous loss is more challenging is that other people may not recognize that a loss has occurred, or, if they do, they may not acknowledge its significance. This lack of recognition can leave a person feeling unvalidated and experiencing a wide range of complicated emotions, leading to complicated or disenfranchised grief (Stein, 2026; Ungvarsky, 2024).

Dr. Boss defined two types of ambiguous loss in her work.

- Physical absence with psychological presence. Examples include:
    - Incarceration
    - Immigration that results in separation
    - Military deployment

    - Estrangement
    - Ghosting
    - Divorce, especially when people lose relationships with those they became related to through marriage. If one person in the relationship did not want the marriage, they may struggle with losing the relationship and the experience of being married.
- Psychological absence with physical presence. Examples include:
    - Dementia
    - A traumatic brain injury
    - Substance use addiction
    - Mental illness
    - A chronic illness
    - When a loss happens that does not make sense, such as a person dying by suicide (Oswald, 2023; Stein, 2026; Ungvarsky, 2024).

When someone dies, there are different ways that a bereaved person can recognize and begin to go through the process of accepting the death, such as planning and/or attending a funeral or memorial service. However, when a person is physically absent, there is a loss, but the same sense of permanence does not come as it does with a death (Ungvarsky, 2024). As stated by Ungvarsky (2024), in these situations "those left behind can alternate between hope that the person will return and fear for the person and what they might be going through. This uncertainty interferes with the grieving process and can make it difficult for people to move past the loss and begin their own emotional healing" (para. 5). In a different type of scenario, when a person is mentally or emotionally absent,

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their loved ones can miss who they were even though they are physically able to see and spend time with the person.

Feelings that accompany this type of loss include sadness, anxiety, guilt, stress, and confusion. A person may have ongoing difficulty with their daily activities, such as eating, sleeping, and socializing. Uncertainty can also affect many parts of a person's life, including their day-to-day mood, identity, finances, and plans. A person may also feel stuck in their grief because the story, with a clear ending, does not happen, making it challenging to make meaning or create a new narrative (Stein, 2026; Ungvarsky, 2024).

Sudden and Traumatic Loss

A sudden loss is "death that happens without warning or time to prepare. This includes car accidents, sudden cardiac arrest, homicide, suicide, or unexpected medical emergencies. The defining characteristic is not just that the person died quickly - it is that you had no opportunity to emotionally brace yourself or say goodbye" (Brenner, n.d., para. 2). According to Worden (2009), sudden deaths overlap with traumatic loss. It may be that the traumatic loss is more impactful than the nature of a sudden death.

When a person experiences a sudden and traumatic loss, they are thrown into the grieving process without preparation, and their entire world has shifted in a moment. This abruptness can leave a person feeling blindsided, disoriented, and shocked as they try to grasp what is happening around them. A person is often left replaying the moment that they found out about the death and grappling with many questions and unresolved emotions. They may look for signs they missed and often struggle with the finality of the loss. They may also think about the missed opportunities with the person who died, such as having certain conversations or saying goodbye.

The feelings that accompany a sudden and traumatic loss include intense shock and disbelief, anger, guilt, self-blame, emotional pain, hypervigilance, and physical symptoms. Depending on how the death occurred, a person may also become isolated if they feel shame or stigma around the circumstances. Research has shown that a sudden and traumatic loss is associated with higher rates of major depression, post-traumatic stress disorder, panic disorder, and substance use disorder for survivors. While not every person develops a mental health disorder, the impact can be long-lasting and often leads to complicated grief, which, as noted above, is diagnosed with symptoms that are intense, impact daily functioning, and persist for at least 12 months (Brenner, n.d.).

Summary

When working with clients who are experiencing grief and loss, it is essential to know the type, as it will help guide their treatment. A clinician can learn more about the type of grief and loss through the assessment process and help clients better understand their experience through education and clinical intervention.

Section 2 Key Terms

Normal grief, which may also be called uncomplicated grief, is “a natural response to loss, with common emotions experienced by most people” (Morrow, 2026, para. 7). It can be thought of as a process that encompasses many different physical sensations, emotions, behaviors, and cognitions that can appear and reappear at different points (Worden, 2009).

Complicated grief is the opposite of normal grief. It results when the process of adapting to the loss lingers, slows, or becomes complicated, and a person has ongoing symptoms. This type of grief can be considered when the intensity of

grief is not decreasing in the months following the loss, considering what is expected based on a person's social, cultural, or religious norms.

Disenfranchised grief can occur when a "loss is unrecognized by others and perhaps not openly acknowledged, publicly mourned, or socially sanctioned" (Doka, 2016, p. 56).

Ambiguous loss is the grief and emotional pain that happens when a person experiences a loss in their life, and they do not have the opportunity for closure or resolution (Ungvarsky, 2024).

Sudden loss is "death that happens without warning or time to prepare. This includes car accidents, sudden cardiac arrest, homicide, suicide, or unexpected medical emergencies. The defining characteristic is not just that the person died quickly - it is that you had no opportunity to emotionally brace yourself or say goodbye" (Brenner, n.d., para. 2). According to Worden (2009), sudden deaths overlap with traumatic loss. It may be that the traumatic loss is more impactful than the nature of a sudden death.

Section 2 Reflection Question

What type(s) of grief do you most often see in your clinical practice?

Section 3: Grief Theories and Contemporary Models of Bereavement

References: 11, 12, 18, 22, 24, 27, 32, 41, 43, 48, 49, 51, 52, 53, 54, 56

Many different grief theories and contemporary models of bereavement exist today. Having knowledge of these theories and models supports an ethical and trauma-informed practice. The theories and models that will be reviewed in this

section include Kübler-Ross's Five Stages of Grief Theory, the Dual Process Model of Coping with Bereavement (Dual Process Model of Grief), Attachment Theory and Grief, Continuing Bonds Theory, Worden's Four Tasks of Mourning, Meaning Reconstruction, Assumptive World Theory, and Growing Around Grief.

Kübler-Ross's Five Stages of Grief Theory

Dr. Elisabeth Kübler-Ross created the original Five Stages of Grief theory in the late 1960s. According to Kübler-Ross and Kessler (2005), this theory has evolved, even as it has been misunderstood for decades. They write that the five stages "were never meant to help tuck messy emotions into neat packages. They are responses to loss that many people have, but there is not a typical response to loss, as there is no typical loss. Our grief is as individual as our lives" (Kübler-Ross & Kessler, 2005, p. 7).

The five stages of grief are denial, anger, bargaining, depression, and acceptance. Each stage is part of a framework that can help a bereaved person learn to live with the one they lost by helping them frame and identify what they are feeling. The stages are not linear or prescribed in a certain order. Not everyone experiences each stage.

When denial was initially introduced in this theory, it was focused on the person who was dying moving on with their life in a state of disbelief that their death was approaching. On the other hand, for a bereaved person, denial is symbolic, meaning that they may have a hard time fathoming that their loved one is gone and they will never be a part of their life in the same way again. When denial is first experienced, a person feels shocked or numb. It is not that the bereaved person does not know their loved one is dead; it is that it is too overwhelming for them to process and get through every day (Kübler-Ross & Kessler, 2005). As stated by Kübler-Ross & Kessler (2005), "denial and shock help us to cope and

make survival possible. Denial helps us to pace our feelings of grief. There is grace in denial. It is nature's way of letting in only as much as we can handle. These feelings are important; they are the psyche's protective mechanisms. Letting in all the feelings associated with the loss at once would be overwhelming emotionally" (p. 10). In everyday life, denial displays itself as questioning reality and retelling the story of the loss. Over time, it moves to questioning the how and why the death happened and trying to understand it by exploring the circumstances involved. As each question is answered, the bereaved person starts to believe the deceased is really gone. With that, the feelings that were being denied start to surface and need to be dealt with.

The stage of anger is focused on the bereaved person and how they may experience this emotion. A bereaved person may be angry at the deceased, oneself, family and friends, other people involved in the circumstances around the death, the situation, the world, or a higher power. While anger is not always logical, it is valid and typically appears once a bereaved person feels safe and reassured that they will survive the loss and all that accompanies it. When anger surfaces, and it will come and go, it is important to acknowledge that it is a necessary part of the healing process. Many other emotions are under the anger and take time to process (Kübler-Ross & Kessler, 2005). As stated by Kübler-Ross & Kessler (2005), "anger means you are progressing, that you are allowing all those feelings that were simply too much before to come to the surface. It is important to feel the anger without judging it, without attempting to find meaning in it" (p. 16). The more that anger is acknowledged as the immediate emotion protecting others, the more other feelings will be processed, and the anger will subside.

Bargaining can happen before and after a loss, and it often changes over time. Before a loss, it can look like a person being willing to do anything if their loved one remains alive. Afterward, it is a "temporary truce" filled with "if only" statements. It often moves from past to future, focusing on things a person hopes

will happen, like seeing their loved ones in heaven or that no other loved ones will become ill. Guilt typically accompanies bargaining, as people often find fault with themselves related to the loss and try to identify things they could have done differently. A person may try to negotiate their way out of the pain they are experiencing (Kübler-Ross & Kessler, 2005). In some ways, bargaining can be "an important reprieve from pain that occupies one's grief. In other cases, bargaining can help our mind move from one state of loss to another. It can be a way station that gives our psyche the time it may need to adjust. Bargaining may fill the gaps that our strong emotions generally dominate, which often keep suffering at a distance. It allows us to believe that we can restore order to the chaos that has taken over" (Kübler-Ross & Kessler, 2005, pp. 19-20). As a bereaved person moves through the bargaining process, their mind processes the "if only" statements; the mind eventually comes to the same conclusion that a loved one has died. There is nothing anyone can do to change that.

After bargaining, a person moves into the present moment and experiences grief responses on a deep level. Some symptoms that they experience may look like depression, such as withdrawing from life, feeling intense sadness, wondering about one's purpose in life, experiencing fatigue, and a change in appetite. However, it is important to understand that these symptoms are appropriate responses to a loss, not a mental illness. Losing a loved one is a depressing situation, so having these symptoms is a normal and appropriate response. The realization that a loved one is not coming back takes time, and experiencing feelings of depression is a step to healing.

Lastly, acceptance is the stage in which a person accepts the reality that their loved one is gone and they recognize that their new reality is permanent. This stage is not about being fine with what happened, but it is about learning to live with the loss and the resulting new norm. This can be challenging at first, as a bereaved person will likely want to maintain their life as it was before. However,

over time, they see that they cannot keep the past intact, and they readjust. They begin to live again and enjoy life, making new connections and relationships. Even though they may feel they are betraying their loved one, they are instead listening to their needs, moving forward, changing and evolving (Kübler-Ross & Kessler, 2005).

David Kessler later identified a sixth stage of grief called meaning, which occurs as a bereaved person moves through pain, not around it. Finding meaning does not have to be something significant; it is often found in ordinary, everyday moments, such as noticing moments of connection or gratitude, honoring a loved one through actions, values, or memories, finding a sense of purpose that develops out of the loss, and making sense of how a loss has changed oneself. Meaning is not rushed or imposed; instead, it unfolds over time, sometimes long after the initial intensity of grief (Kessler, n.d.).

Overall, this theory provides a framework that can help a bereaved person learn to live with the one they lost by helping them understand common experiences after a loss. It is important to keep in mind that a bereaved person will not move through them step by step or on a certain timeline. Because grief is unpredictable, they may feel one stage one day, and a different one the next. Kessler (n.d.) writes that the theory can help a clinician meet people where they are, recognize that grief is a personal experience, and support them as they find their own path through loss.

Dual Process Model of Coping with Bereavement (Dual Process Model of Grief)

The dual process model of coping with bereavement (DPM) created by Dr. Margaret Stroebe and Dr. Henk Schut in the 1990s proposes that “in response to the death of another, a bereaved person engages in loss-oriented (LO) and

restoration-oriented (RO) coping to manage feelings of grief and stressors of everyday life following the loss" (Larsen et al., 2025, p. 743). LO coping has similarities to normal grief, including yearning for the person who died, ruminating about the death, finding meaning in the loss, adjusting the ongoing relationship or connection to the deceased, coming to terms with the loss, and dealing with expected and unexpected grief-related thoughts and feelings. LO coping is often present early in the grief process. RO coping happens when a bereaved person deals with secondary stressors that result because of the loss. Immediate stressors following the death include planning the funeral and handling any legal and/or financial issues. More long-term stressors include taking on new roles and responsibilities and rethinking plans, which can also bring additional emotional distress into a bereaved person's life.

According to Stroebe & Schut (as cited in Larsen et al., 2025), "an adaptive approach to loss is believed to consist of a flexible oscillation between LO and RO coping. It is presumed that one cannot simultaneously attend to both LO and RO stressors; rather, one alternates between confronting and avoiding each of these processes. Consequently, stressors are confronted in manageable doses. This dosing mechanism helps ensure that the demands of the loss do not greatly exceed and overwhelm the person's resources for coping with death" (p. 744). The DPM is not only oscillation between LO and RO, but it is also taking time off from grief and engaging in non-bereavement-related activities. If a bereaved person does not take time off from grief, the model proposes that they are at risk for developing grief complications.

Many years after the model was created, Stroebe and Schut added another challenge to the adaptive grieving process. This challenge is called "overload," which happens when grief demands and loss-related stressors outweigh the bereaved person's coping mechanisms. Overload can cause them to feel pressure, distress, anxiety, or exhaustion, in addition to their grief.

Overall, the DPM offers a framework for thinking about adaptive and complicated grief processes. It is a well-supported theory in the literature and is often used to inform grief interventions, including educational ones. However, it can be difficult to fully grasp and measure oscillation between LO and RO coping because each person's situation is unique. The DPM also does not address how grief changes over time (Larsen et al., 2025).

Attachment Theory and Grief

John Bowlby developed attachment theory in the 1960s. While developing this theory, Bowlby studied infants and separation from their parent(s)/primary caregiver(s) (secure base). Bowlby observed that children displayed attachment behaviors, such as crying, clinging to, or searching for their parent(s)/caregiver(s), to either prevent separation or restore proximity to them. He proposed that these were adaptive responses to separation from a primary attachment figure; one who provides care, support, and protection, and whom children depend on to have their needs met (Fraley, 2018; McGarvie, 2024).

Bowlby also found that a child gained confidence in exploring their environment when they had a secure attachment to their secure base. This idea led him to identify the importance of early relationships and how they can positively shape or negatively impact a person's framework for relationships as they grow older. Therefore, the bond that a person creates with their secure base in childhood has a lifelong impact.

Mary Ainsworth further developed attachment theory by observing interactions between infants, their caregivers, a stranger, and brief periods of separation. By observing the infant's responses to these situations, she identified three primary attachment styles.

- The first is a secure attachment, where the infant is comfortable exploring their environment when the caregiver is present and is distressed when they leave. When the caregiver returns, the infant is easily soothed.
- The second is an insecure-avoidant attachment, where an infant is indifferent to the caregiver's presence and avoids them when they return after a period of separation. This situation shows an emotional disconnection between the infant and their caregivers.
- The third attachment style is insecure-ambivalent/resistant attachment, where the infant is anxious before separating from their caregivers and ambivalent or resistant when they return.

Many years later, Bartholomew & Horowitz added a fourth attachment style called disorganized attachment, in which an infant shows a variety of behaviors indicating confusion or fear toward their caregivers (McGarvie, 2024).

When considering grief, attachment styles provide a framework for understanding grief responses and adjustments to loss. While attachment styles and grief can be complex, in general, for example, when using this lens, a person with a secure attachment style may be able to experience grief-related emotions more comfortably, making it easier to navigate the ups and downs of grief. They may also be able to recall positive experiences with the deceased and continue the bond more readily. A person with an insecure-avoidant attachment style may try to distract themselves from their grief experience by staying busy or distancing themself from their thoughts and emotions. Furthermore, a person with an insecure-ambivalent/resistant attachment style may be helpless or preoccupied by the loss (Shelvock, 2022).

When considering this framework, it is also important to “identify that the internal attachment system is dynamic and fluid, meaning individuals can express

a variety of attachment responses with others in particular settings. Fortunately, since attachment styles are not carved in stone, developing healthier bonds with others throughout the lifespan is fully possible" (Shelvock, 2022, para. 8). When a person is actively grieving, they may look back on their lives, their patterns, and the relationship they held with the deceased. This process can help a bereaved person learn more about themselves, increase their awareness of their attachment patterns with other people, and possibly make changes as they move forward with their life. Shevlock (2022) writes, "Regardless of one's attachment style, it is essential to recognize how those styles are life patterns that are trying to facilitate safety or survival within us. This reinforces how it is much more helpful to find our own pathways in times of loss, given our unique personal needs around attachment. An awareness of attachment theory can support us in becoming less judgmental and more patient with others in their own expressions of grief" (para. 11).

Continuing Bonds Theory

The continuing bonds theory was created by Klass, Silverman, and Nickman (Klass et al.), who developed it after questioning other models of grief that seemed more linear and had a clear point of detaching from the deceased (such as the acceptance stage in Kübler-Ross's Five Stages of Grief). Through their observations, Klass et al. suggested that normal or healthy grief did not resolve when a person separated themself from the deceased, but rather when they created a new relationship with them (also called a continuing bond) (Williams, 2018).

Continuing bonds are "defined as an ongoing inner relationship with the deceased. They include attempts to keep memories alive through dialogue with others, engagement with possessions and photographs, and use of the deceased

as a role model" (Klass et al., as cited in Hewson et al., 2024, p. 1001). Other examples include talking to a loved one, writing letters to them, incorporating them into special days or milestones, taking a trip they always wanted, finishing a project they did not get to, going to places they enjoyed, or eating foods that remind you of them (Williams, 2014).

The idea with this theory is that relationships develop throughout our lives, and when a loved one dies, the relationship does not end; it adjusts and refines itself so it can endure as the bereaved person moves forward with their life. In general, continuing bonds are considered healthy and normal in the grieving process and have been shown to provide comfort and support to a person coping with a loss. They acknowledge that grief is ongoing, that it is normal to stay connected to a loved one, and that they can help people cope with their grief (Williams, 2018). Some questions remain about whether these bonds are helpful or harmful, whom they help and whom they do not, and whether certain points in the grieving process are more helpful than others (Worden, 2009). One literature review of nearly 80 studies involving bereaved adults found that, overall, these bonds bring "comfort, practical support, and distress, with continuing bonds facilitating oscillation between the comforting presence and absence of the deceased" (Hewson et al., 2024, p. 1008).

Overall, continuing bonds theory is supported in the literature as a supportive way for a bereaved person to adjust and cope with loss. In terms of mental health support, this theory provides a framework for helping clients reframe their grief and loss experience and transform their relationship with the deceased (The Loss Foundation, 2024).

Worden's Four Tasks of Mourning

Dr. William Worden initially created the four tasks of mourning in the 1980s. Similar to other professionals who have developed this field, he questioned other bereavement approaches and developed this model based on his own research and observations. He seems to have identified most with language around tasks, as he writes, "the task concept implies that the mourner needs to take action and can do something. Also, this approach implies that mourning can be influenced by intervention from the outside. The four tasks approach can give the mourner some sense of leverage and hope that there is something that they can actively do to adapt to the death of a loved one" (Worden, 2009, p. 38).

The four tasks of mourning are as follows:

Task 1: To accept the reality of the loss

- This task includes a bereaved person coming to fully understand and accept that a person in their life is dead and will not return. Part of this acceptance is understanding that a reunion with the person is impossible in their lifetime. As stated by Worden (2009), "coming to an acceptance of the reality of the loss takes time since it involves not only an intellectual acceptance but also an emotional one" (p. 42).
- Completing this task can be challenging, as people have various ways of searching for the deceased, living in a state of disbelief, thinking the deceased is temporarily gone, and denying the reality of the loss, its meaning, or its irreversible nature.

Task 2: To Process the Pain of Grief

- Worden acknowledges that grief can bring physical, emotional, and behavioral pain to a bereaved person. The levels of pain and types that a

person experiences can vary, but this model outlines that each person experiences some level and type of pain when they lose someone that they love. He writes that it is necessary to acknowledge the pain, talk about it, and work through it to prevent it from manifesting as physical symptoms or unusual behaviors.

- Various ways of completing this task become difficult. Including societal norms negatively influencing how a person processes their pain, and a person avoiding or numbing their pain.

Task 3: To Adjust to a World Without the Deceased

- Every bereaved person goes through adjustment after someone dies. Worden proposed external adjustments, which are how a person functions daily in the world after the death; internal adjustments, which are how one's sense of self changes after the death; and spiritual adjustments, which are how a person's beliefs, values, and assumptions about the world change after the death.

- These adjustments will look different and mean something different to each person. The relationship to the deceased and the various roles that they played in a bereaved person's life are important considerations in this adjustment. This task can take a significant period of time.

- External adjustments can include role changes, increased responsibilities, and learning new skills once the deceased was no longer doing them.

- Internal adjustments can include changes to a person's perception of their self-identity, self-esteem, and sense of self-efficacy. Depending on the circumstances, these parts of a person's make-up may be impacted positively or negatively.

- Spiritual adjustments include how a person makes sense of the world after losing a loved one. Their foundational beliefs about their assumptive world may change positively or negatively. They may feel they have lost their direction, meaning, or purpose.

- Completing this task can become challenging when people fall into helplessness by not developing coping skills or by withdrawing from the world.

Task 4: To Find an Enduring Connection With the Deceased in the Midst of Embarking on a New Life

- This task is for a bereaved person to find an appropriate, ongoing connection with the deceased that also allows them to move on with their life. This task can take a significant amount of time and may be considered the most difficult one to accomplish.
- Completing this task becomes challenging when a person stops living, meaning their life has stopped with the death, and it has not resumed. The bereaved person may be holding on to their past attachment or find the loss so incredibly painful that it is difficult to move on (Worden, 2009).

When writing about the four tasks, Worden (2009) notes, “tasks can be revised and worked through again and again over time. Various tasks can also be worked on at the same time. Grieving is a fluid process and is influenced by the mediators of mourning” (p. 53). These mediators include:

- Who the person who died was
- The nature of the attachment
- How the person died
- Historical antecedents
- Personality variables
- Social variables
- Concurrent stressors

Overall, Worden's model provides an actionable framework for navigating loss. While it focuses on actions that can give a person a sense of control or hope while grieving, the model also acknowledges that grief is not something to complete; it is something to live and grow with. The mediators of mourning can also give context to a person's grief and loss experience. This can benefit some clients doing grief-related work (Worden, 2009).

Six R's Model of Mourning

Dr. Therese Rando created the six R's model of mourning in the 1990s. She writes that while each grief and loss experience is different, reactions can fit within the following three broad phases of mourning:

- **Avoidance** - phase that includes feelings of shock, denial, and disbelief.
- **Confrontation** - phase when intense mourning feelings and psychological reactions to the loss are most acute.
- **Reestablishment** - phase when grief is gradually declining and social and emotional reentry starts happening in the bereaved's life.

Within the three phases, there are six reactions or processes (that all start with the letter "r") that a person may experience:

- **Recognizing** the loss is the process of acknowledging and understanding the death. This occurs in the avoidance phase. When a person dies, the bereaved person's world becomes shaken; they become overwhelmed by the impact of the death, and there is a desire to avoid acknowledging that love is lost. During this phase, a person may initially be shocked, confused, and/or numb. As the process of recognizing the loss begins, denial appears. It serves as a protective mechanism that allows a person to absorb the reality of the loss piece by piece, rather than being completely

overwhelmed. Denial is often considered therapeutic at this point. Disbelief and the need to know why the death occurred will also start to appear. A bereaved person may also feel disorganized and confused in this phase.

- **Reacting** to the separation is the process that occurs when a person has recognized the loss and the shock has worn off to a certain degree. They may still have some denial and disbelief while beginning to experience many new emotions. Not only do the emotions surface, but the bereaved person identifies them, feels them, works towards accepting them, and starts expressing reactions to the death. These mourning-related feelings are very intense and may be felt to an extreme. This occurs in the confrontation phase. The common emotions or reactions that are experienced during this phase include panic or generalized anxiety, anger, guilt, separation, deprivation, anguish, sadness, yearning, longing, depression, and despair. Some emotions, such as sadness, may be easier to express, while others, such as anger, may feel conflicting and a person may be hesitant to express them. In addition to reacting to separation in terms of death, a person also identifies and reacts to secondary losses during this phase.

- **Recollecting** and re-experiencing the deceased and the relationship is a process that requires reviewing and remembering the deceased, while reviving and re-experiencing feelings. This occurs in the confrontation phase. It is a common response for a bereaved person to be preoccupied with the deceased, manifesting as ruminating thoughts, dreaming about the deceased, and searching or yearning for them. They may also review the circumstances around the death and try to restructure them to gain some cognitive control over the situation.

- **Relinquishing** old attachments is the process of identifying with the deceased. This occurs in the confrontation phase (Rando, 1984; Williams, 2013). As stated by Rando (1984), “in appropriate amounts this is not harmful and serves as a way of holding onto parts of a loved one. However, if the identification occurs too intensely, the griever may lose his own sense of personal identity or may seriously impede the grief process by failing to detach from the deceased” (p. 34).

- **Readjusting** is the process in which a bereaved person moves into their new world without forgetting the old one. This mostly occurs in the accommodation phase, but it may wax and wane in the later part of the confrontation phase and continue thereafter. While a person readjusts to their life after loss, they develop a new relationship with the person who died, adopt new ways that they want to live, and establish a new identity. A person may experience guilt as they readjust despite the loss.

- **Reinvesting** is the process of the bereaved person putting their energy into new people, relationships, goals, future planning, and more. This occurs in the accommodation phase. Guilt may also be experienced during this process as the bereaved person may feel that they are betraying the deceased, especially if they enjoy life with another person (Rando, 1984; Williams, 2013).

Rando (1984) writes, “These reactions are colored by both the individual characteristics of the person and pertinent social and psychological factors. The reactions do not form rigid phases, and the griever will probably move back and forth among them. All individuals will not experience all reactions presented; these are only some of the possible responses to a loss” (p. 29). Overall, Rando provides a fluid model for moving through various mourning-related processes. In

clinical practice, it can provide a framework for how a client may be responding to a loss.

Meaning Reconstruction Model

Dr. Robert Neimeyer created the Meaning Reconstruction Model in the late 1990s/early 2000s. He viewed grief as a process in which a bereaved person rebuilds their sense of meaning, identity, and worldview after a loss. This model does not focus on recovery or healing from grief; instead, it focuses on growth as a bereaved person reflects on and understands who they are now, what matters to them, and how they can live a meaningful life after a loss. Neimeyer proposed that meaning reconstruction was primarily accomplished through using narratives and life stories.

By processing their grief and finding meaning through reflecting on their relationship and memories of the deceased, understanding what the deceased meant to them, finding ways to honor them, exploring changes in identity, values, or priorities after the loss, and creating a story that helps them make sense of what happened, a person can redefine themself after a loss and learn ways to engage in the world without the deceased.

Research has found that some deaths do not challenge a person's meaning or purpose in life in a significant way; therefore, it is important to use this framework appropriately. In this situation, a person can explore new meaning in their life. However, overall, in appropriate situations, this model can help a person reconstruct meaning after a loss and move forward in a way that feels most comfortable for them (The Loss Foundation, n.d.; Worden, 2009; Wilson, 2014).

Assumptive World Theory

An assumptive world is “the set of quiet understandings people carry about how life works. Most of us assume that tomorrow will look something like today, that if we put in effort it will matter, that the systems around us will more or less function, that the future is something we can imagine without too much strain. We do not usually think about these assumptions. Instead, we carry them around with little awareness of their presence” (Fireman, 2026, para. 3). Dr. Collin Murray Parkes connected the idea of an assumptive world and grief after working with amputees who were adjusting to a new body and self-image. He found that the loss of a limb resulted in a world that has been radically changed, and for any grief related to these changes to be resolved, a person needed a new assumptive world.

When thinking about an assumptive world in terms of bereavement because of a death, the idea is that when someone dies, it is not only the person who is lost, but it is also the life that was being built with that person. The bereaved person’s life turns upside down. Therefore, grief is more about adjusting to a world that no longer matches plans or expectations, so a person must create a new one (Fireman, 2026).

In the early 1990s, Dr. Ronnie Janoff-Bulman developed an assumptive world theory regarding traumatic loss. She proposed that a healthy world is made up of three basic assumptions: the world is benevolent and meaningful, and the self is worthy. However, when a traumatic event happens, a person is thrown into uncertainty and confusion. A common experience is to question why the traumatic event happened to them or what they did to cause it. Suddenly, the world no longer feels benevolent or meaningful, and a person may no longer feel worthy of living in the world. The traumatic event also takes away a person’s

assumed certainties about their life. They regain their equilibrium when they make sense of their new world and adapt to changes and challenges.

The Assumptive World Theory is helpful in clinical practice because clinicians can listen to a client's description of what the world was like before the loss and how their assumptions have been shattered since. The clinician can help them understand the confusion that has arisen and work with them to describe two new worlds: one pre-loss and one post-loss. When a client can recognize the two, they may be better able to identify what they need to move forward (Wilson, 2014).

Growing Around Grief Model (Circle Model of Grief)

Dr. Lois Tonkin created the Growing Around Grief model in the late 1990s/early 2000s. The idea is that a person can be totally consumed by grief, and instead of those feelings diminishing, grief can remain the same and a person's life can grow around it. In other words, the grief and loss remain a part of a person, and they can engage with the world happening around them. This model can be helpful in clinical practice; it can help a person feel that they are growing and that they do not have to lose or make their grief smaller; their life can become bigger and still be fulfilling even with the loss being ever present (Wilson, 2014)

Summary

When working with clients experiencing grief and loss, theoretical models can provide frameworks that help clinicians understand various experiences, with some providing concrete tasks to support a bereaved person moving through the grieving process.

Section 3 Reflection Questions

Which model(s) do you most identify with in your practice?

Do you find certain ones easily shape your practice, while others may be challenging to work with?

Section 4: Evidence-Informed Assessment and Treatment Approaches

References: 5, 9, 14, 19, 20, 23, 30, 36, 37, 40, 42, 46, 47, 54, 55

Evidence-informed assessment and treatment approaches in social work practice can include using certain screening tools, asking appropriate grief-related assessment questions, and utilizing evidence-based clinical interventions. Having knowledge and skill in these areas supports ethical, trauma-informed practice. This section reviews screening, assessment, and interventions that are focused on grief and loss.

Screening Tools

Clinicians can use many different screening tools as part of the assessment process. A list of some of them, organized by type of grief, is included below.

Normal Grief

- **Hogan Grief Reaction Checklist (HGRC)** - can be used in therapy with bereaved adults to "help them learn about how other bereaved adults have described cognitive, emotional, physiological, and existential/spiritual thoughts and feelings related to the death of a loved one. Learning that others have had similar reactions can help normalize a client's sense of

hopelessness and helplessness. Reading the items could also help clients identify specific issues they wish to discuss with their therapist" (Hogan & Schmidt, 2016, p. 41).

    - This scale includes 61 questions scored on a 5-point Likert-type scale, where people rate how much descriptors of despair, panic behavior, personal growth, blame and anger, detachment, and disorganization describe how they have felt since their loved one died.

- **Grief Experience Inventory (GEI)** - can be used in therapy with bereaved adults to help them identify the specific areas of grief-related distress that they are experiencing and the severity of them. It can help a clinician better understand the impact of a loss on a bereaved person and guide treatment planning.

    - This inventory includes 135 questions that assess emotional and behavioral experiences of grief (Kron, 2026).

Meaning Making and Reconstruction

- **Grief and Meaning Reconstruction Inventory (GMRI)** was developed to measure how a bereaved person finds or makes meaning following a death-related loss.

    - This inventory includes 29 items rated on a 5-point Likert scale from strongly agree to strongly disagree. The statements fall into five categories - continuing bonds, personal growth, sense of peace, emptiness and meaninglessness, and valuing life - and assess thoughts, feelings, beliefs, and meanings a bereaved person may experience after a loss. It can help a clinician identify negative emotions and distress, symptoms of complicated grief and mental

health, as well as positive correlations with grief-related growth (Neimeyer et al., 2016).

- **Integration of Stressful Life Experiences Scale (ISLES)** - developed to "assess the degree to which there is (or is not) a discrepancy between the situational meaning made of a particular life event (i.e., appraisals and reappraisals of the event and its significance or meaning) and one's sense of global meaning (i.e., overall beliefs, goals, and worldviews)" (Holland, 2016, p. 46). It is a general-purpose measure of the meaning a bereaved person makes of stress. It has been supported in the literature when used with military veterans, older adults with depression, college students with various stressors, and those who have lost a loved one.
    - This scale includes 16 meaning-related statements rated on a 5-point Likert scale from strongly agree to strongly disagree. These statements all focus on the discrepancy between situational and global meaning of a loss to help a clinician understand how their client is processing and possibly making meaning of the loss (Holland, 2016).

Complicated Grief and Prolonged Grief Disorder

- **Brief Grief Questionnaire (BGQ)** - was developed to identify prolonged grief disorder quickly.
    - This questionnaire includes 5 questions to assess grief-related symptoms (Szuhany et al., 2021).
- **Prolonged Grief Disorder-13 (PGR-13)** - developed to measure grief-related thoughts, feelings, and actions to help identify if a bereaved person is experiencing prolonged grief disorder.

    - This tool includes 13 items that examine three aspects of prolonged grief disorder symptoms, including a person's thoughts, feelings, and actions over the past month. Questions ask about the frequency of separation distress, the extent of cognitive, emotional, and behavioral problems resulting from the loss, and the level of impairment (Szuhany et al., 2021).

- **Inventory of Complicated Grief (ICG)** - developed to help identify indicators of complicated grief (yearning, intense sorrow, avoidance, anger, disbelief, and difficulty accepting the loss), quantify symptoms, and understand their severity. This tool was mainly used before the diagnosis of prolonged grief disorder was developed and added to the DSM.
    - This scale includes 19 items related to complicated grief symptoms. These statements are rated on a 5-point Likert scale of how often the symptoms are experienced, from never to always. The higher a person scores, the more likely they are to experience ongoing difficulties in their personal, social, and occupational functioning (Kron, 2026; Psychology Tools, n.d.).
    - An Inventory of Complicated Grief-Revised is also available and includes 15 questions related to complicated grief (Guldin, 2011).

Disenfranchised Grief

- **Witnessing of Disenfranchised Grief (WGD)** - developed to assess the degree to which a bereaved person perceives their loss to be witnessed.
    - This scale includes 22 items rated on a 5-point Likert scale from strongly agree to strongly disagree (St. Clair, 2013).

Ambiguous Loss

- **Ambiguous Loss Inventory Plus (ALI+)** - developed to identify ambiguous loss symptoms.
    - This inventory is a three-part measure. As stated by Robbins (2023), "the first two parts, drawing on existing measures of grief and loss, are designed to assess losses that may be ambiguous and note the relationship to the missing person. They also seek to capture grief-like reactions to ambiguous loss in a process similar to those used to measure the impacts of prolonged grief disorder. The third part consists of impacts of ambiguous loss, the list of which was developed following a literature review and an expert meeting. These impacts include, for example, intrusive thoughts, feelings of stasis, family tension, and concern that rituals for the dead have not been done. This list of impacts was reviewed by small groups of both relatives of missing persons and experts to ensure comprehensibility and relevance" (para. 6).

Sudden and Traumatic Loss

A systematic literature review conducted by Ennis et al. (2023) found that the most commonly used screening tool for sudden and traumatic loss was the Inventory of Complicated Grief-Revised (included above). Studies examining this type of loss also used the PGR-13, Traumatic Grief Inventory-Self Report, Complicated Grief Assessment-Self Report, and the Texas Inventory of Grief, among others.

Evidence-Informed Assessment

A screening tool can complement a clinical assessment. Before a client begins one-on-one therapy, an experienced, qualified clinician can administer a screening tool along with an assessment. As stated by Kron (2026), “effective grief assessment requires more than identifying that a client has experienced a loss - it involves a structured evaluation of how that loss is impacting their functioning, symptoms, and overall well-being. Clinicians must gather information across multiple domains to determine whether a client is experiencing typical grief, is at risk for complicated or prolonged grief, or requires a higher level of care” (para. 15).

According to Wilson (2014), there are two elements to assessment:

- To determine if the model of support that the clinician offers is appropriate to meet the client’s needs.
- To assess any risk factors that may arise when working with the client.

Wilson (2014) writes that it is ideal for the assessment process to take place where future counseling sessions will be held, as it provides reassurance and consistency to a bereaved client. Possible locations include an office setting or the client’s home. Next, remember that this may be the client’s first time telling their story of the loss and talking about their thoughts and feelings related to it. Wilson recommends using techniques to help the client feel as comfortable as possible, including a warm greeting, gentle smile, and active listening with undivided attention (not writing or documenting during the session, if possible). At this stage, the most important goal is to understand the client’s story and possible needs.

Determining Client's Needs and Appropriate Supports

As stated above, one element of an assessment is to determine whether the model of support the clinician offers is appropriate to meet the client's needs. This conversation can start by asking the client questions, including what brought them to the assessment and why they have chosen therapy now. An event may have triggered a reaction that made a client feel they needed help, or their situation may be compounded by events that have happened since the death, or by past and concurrent losses. Listening to the content of the story and how it is told is essential (Wilson, 2014). As stated by Wilson (2014), "the content will inform you of the likelihood that this client's grief will be complex or prolonged. The way the story is told will give you an insight into how the client is managing his grief. It should also give you clues as to the readiness, willingness, and ability of the client to form an effective therapeutic alliance" (p. 184).

Listening to the client's story can include being attuned to information that helps the clinician identify the loss, including who or what was lost, when the loss occurred, the client's relationship to the loss, and whether the loss was sudden or anticipated. This can clarify the nature and context of the loss. The clinician will also want to gather information about symptoms the client has been experiencing, including emotional, cognitive, physical, and behavioral symptoms. This can evaluate the presence, severity, and duration of symptoms. Next, the clinician will want to learn more about the client's impairment to evaluate it. This includes learning more about the impact of the loss on the client's work, school, or daily functioning; any strain in relationships; their ability to experience positive emotions; and whether they can identify a sense of purpose and meaning (Kron, 2026).

While listening to the client's story, the clinician can learn more about what coping strategies they have been using and what support systems they have in

place. They can also learn more about the client's cultural and spiritual belief system (Wilson, 2014). The way a client tells a story can "give you an indication of their grieving style" (Wilson, 2014, p. 185). For example, if the client is unemotional, tells the story with few details, and needs prompting from the clinician, this suggests they are trying to maintain control (Wilson, 2014).

In addition, the clinician will need to screen for risk (more information noted below) and any comorbidities the client may have. These can include prolonged grief disorder, depression, anxiety, post-traumatic stress disorder, and substance use. Comorbidities can also include medical conditions and medication effects. This information provides more context about the client (Kron, 2026).

Furthermore, while listening to the client's story, the clinician can assess whether the client is ready, willing, and able to use counseling effectively by identifying their needs and using professional clinical judgment to determine whether therapy would meet them. Client readiness, such as a self-referral, is often a strong predictor of a positive outcome (Wilson, 2014). Wilson (2014) suggests "the stages of preparation for grief counseling are concerned with accepting the reality of the death, becoming prepared for the pain of grieving, and facing the uncertainty of moving forward without the lost loved one" (p. 188). These can be appropriate indicators to listen for during the assessment to determine readiness. If the client is deemed ready for counseling, they will likely be willing to enter a therapeutic relationship, but exceptions exist.

When assessing willingness to use a counseling model of support (also known as an evidence-informed treatment approach), a professional judgment is made about the client's ability. These judgments are made during the active listening process, which includes listening for the client's ability to reflect on their feelings and behaviors, in particular, how they were before the loss and how they are now after the loss (Wilson, 2014). As stated by Wilson (2014), "if a client can give a

coherent account of both his actions and emotional processes, can describe the link between the two and can understand aspects of his grieving in psychological terms, then this is the evidence that I need to conclude that he is psychologically minded (or able to make effective use of counseling)" (p. 189).

Psychosocial functioning is another factor in determining a client's ability to benefit from counseling. Clients with high levels of psychosocial dysfunction, underlying mental health issues, personality disorders, and dependence on other people, as well as a less secure attachment style, often get the least benefit from grief counseling. However, skilled practitioners must be realistic about the degree to which they can help a client and do their best to support them, which may not only be related to their grief, but also learning how to use counseling effectively and connect with other clinicians or resources that can help support them with their psychosocial functioning.

Assessing and Determining Risk

Another element of assessment is evaluating the client's risk to themselves and to others. Clients can be considered to be at risk to themself if they are engaging in substance and alcohol abuse, neglecting oneself, engaging in other forms of dangerous risk-taking behaviors, and experiencing suicidal ideation. It is important to assess these aspects of risk by asking a client whether they have a history of or are currently using substances, if they are taking care of themselves, if they have participated in any self-harm behaviors, and completing a suicide risk assessment.

Regarding risk to others, the clinician needs to consider whether the client could harm others or the agency/organization where they work. One example of assessing harm to others would be learning about the client's behaviors and assessing if they are using substances and/or if they present to a session under the influence of them.

Completing the Assessment

After completing the assessment, the clinician can use clinical judgment to determine whether a client is appropriate for therapy and the level of care they may need (Kron, 2026; Wilson, 2014).

Evidence-Informed Treatment Approaches

Many different evidence-informed treatment approaches exist today to support clients who are experiencing grief and loss. These approaches can vary greatly depending on the bereaved person's needs and the level of interruption they are experiencing in their daily life. When considering treatment approaches, a clinician needs to keep in mind that "grief is a natural normal process and should not be treated as a disorder, unless it reaches a level of complexity or persistence which cannot be supported through typical grief approaches" (Kron, 2026, para. 34). This section will review some evidence-based interventions that are used in clinical practice.

Companioning Model of Grief

The companioning model of grief, created by Dr. Alan Wolfelt, is the process of being on a bereaved individual's journey with them, allowing them to lead their own experience and reflect on it. This focuses on support rather than formal treatment for grief. The model outlines 11 tenets of companioning, including being present in someone else's pain, listening with heart, bearing witness to struggle, learning from others, exhibiting compassionate curiosity, and more (Center for Loss & Life Transition, 2019).

Acceptance and Commitment Therapy (ACT)

When acceptance and commitment therapy (ACT) is used in clinical grief work, it promotes the nature of grief as something that is a common experience all people will go through. It recognizes that grief is expected and focuses on accepting what cannot be changed or controlled. People learn how to accept painful emotions, practice mindfulness, and identify value-based actions they can take while grieving. The focus is on building a meaningful life and processing feelings that arise during the grief process. These skills can be especially helpful for people who are experiencing ambiguous loss and those who struggle a great deal with uncertainty in their bereavement (Kron, 2026; Lyons, 2025).

Narrative Therapy

Narrative therapy gives a bereaved person the opportunity to complete their own storytelling around the loss, which helps them navigate their stories and can support reframing the experience. Ultimately, this can help them reinvest in their life moving forward. This approach can help clients who benefit from more than talk therapy alone to identify and understand the complexity of their loss.

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) is an approach that can help reduce symptoms. It can increase acceptance of a bereaved person's thoughts and feelings related to the loss and decrease symptoms of complicated grief by rewiring unhelpful thoughts, feelings, and behavior patterns. It is considered a trauma-informed approach in grief therapy (Kron, 2026).

Complicated Grief Therapy (CGT)

Complicated grief therapy (CGT) is specifically designed for people who experience complicated grief/prolonged grief disorder. According to Kron (2026),

“it integrates elements of interpersonal therapy and CBT with grief-specific components including revisiting the loss story (imaginal exposure), addressing situational avoidance, and facilitating imaginal conversations with the deceased” (para. 38). These exercises can help a bereaved person with accepting the loss, restoring functioning, and finding ways to remember their loved one while re-investing in their life (Lyons, 2025). Complicated grief therapy is the recommended first-line of treatment for a person who has been formally diagnosed with a prolonged grief disorder.

EMDR for Traumatic Grief

Eye movement desensitization and reprocessing (EMDR) can be an effective intervention when a bereaved person’s grief is complicated by traumatic elements, such as a sudden or violent death, or if they have witnessed the death. It focuses on traumatic aspects of the loss to reduce intrusive re-experiencing and hyperarousal. EMDR for traumatic grief can be considered when a client has a prolonged grief disorder and post-traumatic stress disorder (Kron, 2026).

Support Groups

Grief and loss support groups can connect clients with others who understand what they are going through. Sharing personal experiences in a group setting can help a client feel less isolated while learning practical coping strategies. Support groups can be especially helpful when a client feels that their family members and friends do not fully understand the grieving process. Instead, they can find support in others that they can relate to (Lyons, 2025).

Other Therapeutic Modalities

Many other therapeutic modalities and techniques can be used in bereavement work. Some of them may be more useful depending on the type of grief a client is

experiencing. One technique is rituals, which “usually involve an action that is initiated on the part of the bereaved individual to give a symbolic expression to certain feelings or thoughts” (Winokuer & Harris, 2012, p. 152). They can provide meaning to the bereaved person and connection to the individual who died. Rituals include funeral or memorial services, visiting a grave, displaying photographs, having a linking object (e.g., jewelry), writing letters, doing an activity that evokes memories of the deceased, and many others. Mindfulness-based interventions may also be helpful in grief work, including body scanning, deep breathing, or following the breath. Sandtray work is another technique that allows for play and processing (Winokuer & Harris, 2012). Tapping, yoga, loving-kindness meditations, story writing, letters to self, photography, and other forms of art are some of the many therapeutic modalities and techniques that can also be used in grief work (Neimeyer, 2016).

Summary

When working with clients experiencing grief and loss, it is important to select an appropriate screening tool (if used in practice) and to conduct a complete grief assessment that allows the clinician to determine the appropriate level of care and therapeutic approaches a client will benefit from throughout the grieving process.

Section 4 Reflection Question

What evidence-informed screening and assessment practices and therapeutic approaches do you use when working with clients?

Section 5: The Impact of Grief and Loss on Helping Professionals

References: 25, 55, 56

Working with clients experiencing grief and loss can be a unique area of practice, with its own challenges and rewards, professionally and personally. Worden (2009) writes that many clinicians enter the profession to help others, but grief can, in some ways, preclude that ability. In some cases, the experience of grief can make it difficult for the clinician to be or feel helpful, leading to feelings of discouragement, frustration, and anger. It may also be difficult to bear witness to another person's ongoing pain, which can reduce effectiveness or engagement in the work.

Personally, grief and loss work can make a clinician aware of their own losses, especially if they have experienced a similar loss to their clients. If this loss is not adequately worked through, it can impair the clinician's ability to provide meaningful or helpful interventions. If the loss has been integrated into a clinician's life, it can serve as a beneficial counseling intervention. Another way grief and loss work can impact a clinician personally is when they fear certain losses in their life and work with clients experiencing the same types of losses. Furthermore, existential anxiety and one's own personal death awareness can present challenges to a clinician. Clinicians who work in grief and loss are put in touch with their own mortality, and depending on how they are processing it, their work may be negatively impacted.

Because of these professional and personal impacts of grief and loss work, clinicians are encouraged to explore their own history of losses. This can help them better understand the bereavement process, what grief feels like, coping strategies, and how long the process can persist before it feels adequately

resolved. It can also increase self-awareness by identifying thoughts, feelings, or behaviors that may need to be addressed during this type of professional work. Additionally, it can help them understand the resources available to the bereaved and support their interventions. Lastly, exploring loss history allows the clinician to acknowledge and be mindful of their limitations with respect to clients and the types of situations they can work with (Worden, 2009).

Worden (2009) shares one example of a loss history and encourages clinicians to do this exercise by completing the following sentences:

- The first death that I can remember is:
- I was age:
- The feelings I remember having at the time were:
- The first funeral (or other service) I ever attended was for:
- I was age:
- The thing I remember most about that experience is:
- My most recent loss by death was:
- I coped with this loss by:
- The most difficult death for me was:
- It was difficult because:
- Of the important people in my life who are now living, the most difficult death for me would be:
- My primary style of coping with loss is:
- I know my own grief is resolved when:

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- It is appropriate for me to share my own grief experiences with a client when: (p. 254-255)

In addition to completing a loss history, there are other self-care techniques for managing the emotional impact of the work, including.

- Recognizing your limitations and setting limits. If a clinician is working with dying patients, they must know their limitations in terms of how many people they can work with in this situation; if they cannot control this number, they can still recognize their limitations and be mindful of their involvement and attachment to these patients. A clinician must recognize that they are a human being with a capacity to care for others that relies upon the capacity to care for themselves.
- Knowing when to reach out for help, how to do it, and whom to lean on for support. These may include personal connections, such as family or friends, as well as professional connections, such as teammates or managers. Seek regular supervision and opportunities to debrief. If a clinician is working on a professional team, they may work together to create a ritual or another way to acknowledge the person who died and process their grief together. A clinician may also need to strengthen their support and can do so by connecting with others, joining groups or various communities (Winokuer & Harris, 2012; Worden, 2009).
- Practicing active grieving when someone dies. This includes experiencing sadness and other emotions and possibly attending the funeral service (Worden, 2009).
- Compartmentalizing. Putting psychological distance between work and personal life. Creating a ritual to decompress from the day. Trying to keep

the mind present in the moment and not crossing over between situations (Larson, 1993).

- Monitoring well-being and practicing a healthy lifestyle. Taking care of one's physical health, including eating healthy and exercising, helps manage stress. Being aware of the body's signals that indicate significant work-related stress, such as disturbed sleep and frequent illnesses.
- Seeking professional counseling. Having a space to process losses and cope with them can promote resilience and growth personally and professionally.
- Cultivating self-awareness. Create an understanding of issues, thoughts, feelings, and values to separate them from a client's.
- Other self-care techniques include relaxing the physical body (e.g., meditation or breath work), practicing self-compassion, maintaining a reflective practice (e.g., journaling), and connecting with faith or spirituality.

Professionally, it is also critical for a clinician to align with a professional code of ethics and standards, as this provides a professional grounding and a guide to reference in challenging times (Winokuer & Harris, 2012).

As stated by Winokuer & Harris (2012), "Self-care is a professional competency. Our most important asset as counselors is our ability to care and to share in human compassion; it is of vital importance that these aspects of ourselves be nurtured, guarded, and protected so they will be available when we want and need them in our lives, both personally and professionally" (p. 204).

Summary

Working with clients experiencing grief and loss can be challenging personally and professionally. Clinicians need self-awareness and self-care practices to promote resilience and growth in the field.

Section 5 Reflection Questions

What has been the impact of working in grief and loss in your life?

What self-care practices do you use currently?

Are there opportunities to improve your own self-care?

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