A Systems-Based Approach to Supporting Individuals Who Have Experienced Grief and Loss

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SAMHSA
Substance Abuse and Mental Health Services Administration

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Abstract

It has been estimated that 27 million people are impacted by bereavement as a result of the approximately 3.1 million deaths in the United States every year.[1] The death of a loved one is a universal experience and one of the most severe stressors in a person's life. Grief is the natural response to bereavement that can be intensely painful, disorienting, and disabling, often affecting the health and mental health of those who experience it.[2] Yet health, mental health, and substance use service providers and service systems leaders often fail to recognize and understand grief and thus do not provide the support grieving individuals might need. Parallel to the work of trauma-informed services, promoting grief literacy as well as offering an organized approach to grief interventions can benefit support staff and recipients of services and provide a common platform from which to improve the care of people who are in mental health services and the care of people who serve them. This paper presents a G.R.I.E.F. framework for system leaders and policymakers to help set an intention to shape grief-informed service delivery systems. Doing so would equip everyday service providers with knowledge and skills to walk alongside individuals experiencing loss; to gain their trust; and to validate, support, and guide them on their grief journey. The G.R.I.E.F. framework outlines five core principles to guide the development and implementation of high-quality grief-informed services throughout the community and within clinical service systems.

Highlights

- Grief is a continuation of love that evolves from a feeling that love has nowhere to go.
- Prolonged grief, now a formal *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* diagnosis, occurs when intense grief is persistent and unrelenting, impairing a person for a period longer than expected by their culture, religion, or community. Prolonged grief is associated with many mental and physical health complications including elevated rates of suicidality.
- Prolonged grief therapy focuses on a set of "healing milestones" that are organized around information and experiences designed to help people with prolonged grief accept the reality of their loss and restore their capacity for well-being.
- Having a structured approach to grief-informed services can help policymakers, providers, and persons with lived experience support and be supported during times of bereavement and loss and potentially help improve functioning and social connection.

Recommendations

Policymakers and providers should embark on enhancing grief support through dissemination and utilization of this G.R.I.E.F. framework to better organize, structure, and maximize evidence-based and recommended approaches to grieving people.

G.R.I.E.F. FRAMEWORK

Guiding Principles for Healing After Loss

G — **Grief literacy development** through understanding and use of information and lived experience in ways that promote adaptation to loss

R — **Restoration of meaningful relationships** and sense of personal agency and competence as a component of grief support

I — **Interconnectedness of formal and informal support providers and support** for social integration in reducing isolation

E — **Empathy for loss survivors** and validation of individual loss experiences

F — **Facilitation of understanding and non-judgmental acceptance** of the impact of loss and grief and of ways to thrive after loss

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Introduction

Bereavement and grief are universal human experiences. Grief is often intensely painful, disorienting, and disabling. Although it is a natural response to loss, grief can affect the health and mental health of those who experience it.[3] Yet health, mental health, and substance use service providers and service systems leaders, like others, often fail to recognize and understand grief and do not provide sufficient support for grieving individuals.

According to the American Psychological Association, grief is defined as "the emotional, psychological, and behavioral response to a significant loss," whereas bereavement is "the state of having experienced that loss, specifically a loss due to death."[4] Drawing upon this conceptual definition, this paper uses the term *grief* to refer to the response to a meaningful loss, which can include physical, mental, spiritual, and social components, while bereavement refers to the situation of having lost someone close. Grief is complex, multifaceted, variable, and unique to each person and each loss. It is most commonly recognized as a response to bereavement, though a growing body of literature highlights the significance of grief from nondeath losses, such as job loss, divorce, or being cut off socially from others.[5] This paper will focus primarily on grief after the death of someone close.

Definition of Terms

- Grief: the response to a meaningful loss that includes physical, mental, spiritual, and social components
- Bereavement: the situation of having lost someone close

"Grief is a natural response to loss, not itself a mental disorder."

Health and mental health clinicians play a role in supporting grieving individuals. To do so, it is important that they recognize grief, which requires differentiating it from symptoms of common mental disorders. Grief often includes deep, unregulated emotional pain; troubling cognitions and defensive coping behaviors; social and spiritual challenges; and difficulty engaging in ongoing life activities. Despite profound distress and interference with functioning, grief is a natural response to loss, not itself a mental disorder. Grief is often mistaken for depression or post-traumatic stress disorder (PTSD), which can lead to misdiagnosis and unsuitable treatment and can worsen the experience for the grieving person. Mental health and other support providers should be able to talk about grief with bereaved individuals, honoring each person's unique grief experience, and should be aware of interventions that are effective for individuals who are grieving. They should also be able to talk to and offer information to individuals in the grievers' lives who are standing by them on their grief journey.

The United States is facing a period of significant rates of bereavement. For every death, it is estimated that nine people will be affected by bereavement, though this number varies quite a bit by the nature of the death, the age of the decedent, and the social connectedness of the individual who died.[6] Still, with about 3.1 million people dying in the United States in 2023, there would be approximately 27 million people each year experiencing bereavement.[7]

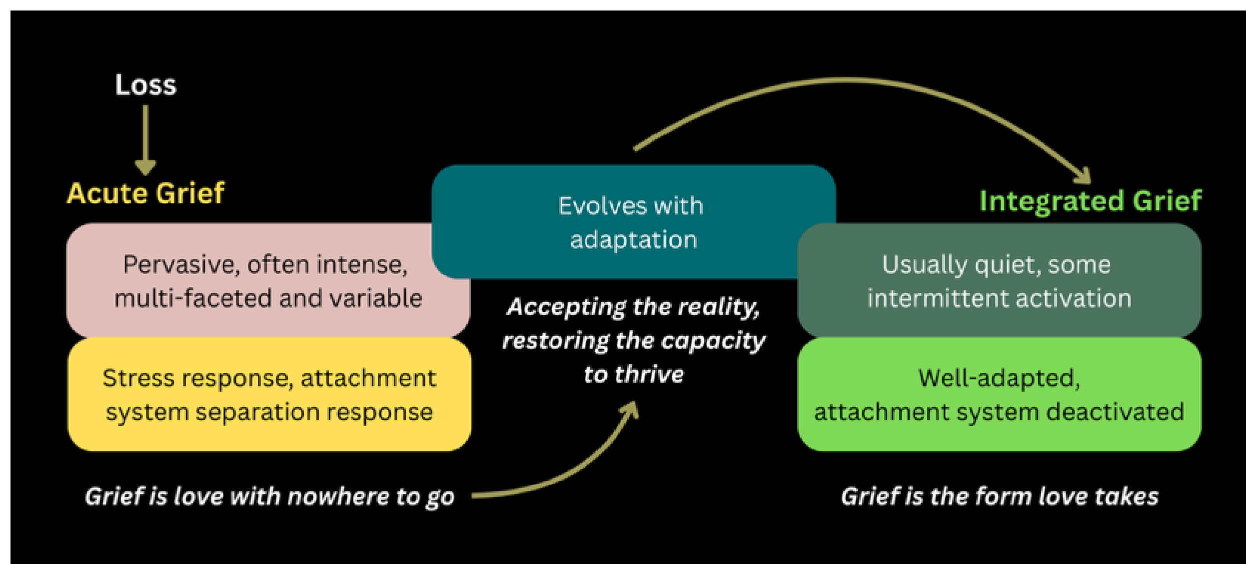
RECOGNIZING GRIEF AND UNDERSTANDING WHY WE GRIEVE

Loss of someone close is one of life's most severe stressors. The loss of a loved one can cause preoccupying thoughts and uncontrollable emotionality, intense feelings of loneliness, and changes in a person's sense of self. It can undermine feelings of importance and belonging and initiate changes in family dynamics, feelings of exclusion from social groups, and new responsibilities. The grief process also includes inherent contradictions, such as wanting grief to go away and also feeling it is all that is left of a loved one; wanting to be free of pain and also feeling pain is warranted; wanting to move on yet feeling it is wrong to do so; feeling a need for support from other people but finding it hard to connect and accept support; or craving connection to the person who died even while reminders of them feel too difficult. Grief, therefore, is a severe, compound stress response to separation from an important person.

Each person experiences grief differently, even when bereaved of the same person. An individual grieves differently when bereaved of different people. There are many factors that influence how someone experiences grief, including their relationship with the person who died, how and when the death occurs, and who is around to support them. Other influences include characteristics of the bereaved person, such as age, past experiences, personality, coping style, changes in their life, and social and environmental context. Grief also can be affected by characteristics of the deceased, such as age, personality, social roles, and other relationships. However, there are common principles of grief that can guide both formal and informal grief-focused interventions. Common elements of the response to loss can be understood through the lens of relationship theory and research.

Behavioral motivational systems are among the most well-researched models for understanding the underpinnings and the loss of a close relationship.[8] Attachment, caregiving, and exploratory systems are especially relevant to understanding bereavement and grief. Being effectively cared for is most important in childhood, while being an effective caregiver becomes more central in adulthood. Our brains store complex internalized representations of loved ones,[9] and these mental representations operate largely outside conscious awareness and function as "working models" that shape how we think, set goals, and make plans.[10] Evidence suggests that working models of close relationships also may help regulate psychological processes such as emotion and attention regulation,[11] tolerance of ambiguity,[12] suppression of unwanted thoughts,[13] and sense of self.[14] They further influence physical processes including sleep,[15] appetite,[16] pain perception,[17] cardiovascular reactivity,[18] and neuroendocrine[19] and immune functioning.[20]

Figure 1: A Way To Conceptualize Grief, From Center for Prolonged Grief, Columbia School of Social Work



Under ordinary circumstances, these attachment working models remain in the background of daily life. However, if a relationship with a loved one is seriously threatened, the attachment and caregiving systems become activated, drawing attention to themselves. This activation generates frequent, insistent thoughts of the loved one; a strong impulse to seek proximity to them; and a range of strong feelings including yearning, longing, sadness, separation anxiety,[21] guilt, and/or anger (**Figure 1**).[22] A significant separation from or loss of a loved one draws attention to their importance and destabilizes these working models, disrupting their regulatory influence on psychological and physiological functioning.[23]

This loss of attachment security is accompanied by inhibition of the exploratory system, resulting in a loss of curiosity, interest in learning and growing, risk taking, and achievement and fostering a turning inward.[24] This combination of mind and body changes is recognizable as a common element of early grief. Framing grief as a natural separation system response validates and normalizes this painful and disruptive experience and invites understanding grief as a continuation of love and a feeling of love with nowhere to go.

As the finality of loss is understood and accepted and the mental representation of the deceased is revised to expect their absence, psychological and biological systems recalibrate. The attachment system quiets, the exploratory system reawakens, and interest and engagement in ongoing life is restored. Important though, memories of a deceased loved one are not erased. As the person adapts to the new reality over time, early, overwhelming grief evolves into a quieter, more unobtrusive, and bittersweet form—a lasting expression of love transformed by loss.[25]

"Framing grief as a natural separation system response validates and normalizes this painful and disruptive experience and invites understanding grief as a continuation of love and a feeling of love with nowhere to go."

It is natural for individuals in helping roles to make judgments about what is or is not healthy or expected, how long grief should last, and other aspects of another person's bereavement experience. It is natural to try to find something to help or "fix."[26] It is important to be aware of this impulse and to resist it. Formal and informal grief support providers must understand and nonjudgmentally accept the wide variability in how people experience, express, and move through grief and resist the urge to tell the person to change the way they are grieving. This is described further below.

A common misconception of grief is that fully confronting reminders of a lost loved one is a necessary part of coming to terms with a painful loss. As articulated by Bowlby and by Stroebe and Schut, effective coping involves alternating between avoiding and confronting reminders of the loss.[27, 28] Although excessive avoidance can lead to prolonged grief,[29] when supporting a grieving person, it is most helpful to collaborate with them in finding a balanced way of living with reminders of their loss.

Another misconception is that grief should eventually be resolved or completed. With natural internal psychological mechanisms and adequate support, most people find their way forward to a life with possibilities for joy, satisfaction, and meaningful relationships.[30] Even still, grief continues indefinitely in the new form of love or attachment over the long run.[31] Memories of and feelings about a deceased loved one continue to be present, though eventually typically in the background. Many bereaved people continue to experience episodic intensification of grief when confronted with certain kinds of reminders of the person who died, often related to calendar days.[32] This can occur even long after a bereaved person has made peace with their loss and restored their capacity for well-being. These kinds of grief surges are, as is grief generally, best supported by empathic presence, validation, and support.

LIVING WITH LOSS AND THE NATURAL EVOLUTION OF GRIEF

Even when a death is expected, the initial experience of bereavement is often an incomprehensible shock. Of course, the shock is even greater after a sudden unexpected loss. In either case, the grief that accompanies the loss can be overwhelmingly intense. In the words of John Bowlby, the idea that a "loss is permanent, may be more realistic; yet at first it is altogether too painful and perhaps terrifying to dwell on for long.[33] In this early aftermath, a bereaved person usually engages in personal and social rituals and other activities focused on the death, surrounded by supportive friends, family, funeral professionals, clergy, and others. These activities are the primary focus of attention, as the bereaved individual begins to confront the painful reality of life without their loved one. As the rituals and support wane, the bereaved person begins an extended process of learning how to live with their loss. They need to understand and accept the reality of their loss and the changes it brings, the presence of grief in their life, and a changed relationship to the person who died. Learning to live with the loss also entails finding ways to connect with their own interests and values, restoring their sense of agency and competence and rebuilding meaningful relationships in a world without their loved one. As these processes progress, their relationship to the person who died changes, and grief diminishes in intensity and becomes more bittersweet.

Quotes from bereaved people about the acute phases of grief:

- *"I threw things."*
- *"I yelled a lot at everyone near me."*
- *"I tried to control the world around me."*
- *"I observed his utter withdrawal."*
- *"I blindly followed the rituals of my faith."*
- *"I felt numb."*
- *"I couldn't tolerate hearing happy banter that seemed so trivial."*

It is helpful for bereaved people, as well as their friends, family, and the community at large, to understand and accept without judgment the natural occurrence of intense, unrelenting grief, even when accompanied by distressing grief-motivated behaviors like crying, sobbing or wailing, periods of determined withdrawal, or expressions of anger that might include yelling or even throwing things. In this way, a grieving individual can be supported by strong, compassionate relationships that are important aides to a bereaved person's finding their way forward. When the responses are maladaptive or unsafe or when they create ongoing dysfunction, additional support may be needed. As stated previously, grief, in whatever form it takes, is a natural response to the experience of a loss, and it can take many forms.

Grief in children and youth

Children experience and express grief differently than do adults.[34] One especially striking difference is the way children can move in and out of grief very rapidly. This is sometimes called "puddle jumping." In general, children's emotions can escalate and de-escalate much more quickly and frequently than adults'. This can be confusing to grieving parents and other adults who do not recognize this as typical for grieving children. Even teenagers may not react to death as adults usually do; for example, they may have behaviors that look like acting out or distress or engage in higher-risk behavior. The presence or absence of a well-attuned, responsive caregiver can affect a child's experience of loss and grief, as can the caregiver's own expression of grief and the expectations and behavior of others in their community. This can be challenging in family systems experiencing loss together.

Figure 2: Examples of Grief Experiences During Stages of Development

Ages 0–2: Babies and younger toddlers can sense a change in environment or an absence yet may be unable to grasp that a loved one is missing. Their response may manifest in disrupted behaviors such as increased clinginess, inconsolable crying, irritability, or difficulty sleeping or eating.

Ages 3–5: Older toddlers and preschoolers may be aware that the person is missing and experience a separation reaction with anxiety, disinterest in usual playful activities, clinginess, irritability, or sleep or appetite disturbance. They may understand that something is wrong with their person and be worried that they are in pain because they have trouble understanding the permanence of death.

School-aged: Around age 5–7, children will usually start to comprehend the idea that death is final and irreversible and something that happens to everyone. However, the emotion regulation and cognitive capacities underlying this understanding may wax and wane as the stress of the loss can undermine recently acquired developmental capacities. Guilt about the loss also may emerge.

Older children and teens: As a more accurate understanding of death evolves with accompanying comprehension of the permanence of the loss, a child's concerns may shift to thinking they are responsible for the death. They also may be prone to magical thinking: imagining there might be something they could do to make the person come back or worrying that if they do or do not do certain things, others will die.

Source: https://www.childbereavementuk.org/childrens-understanding-of-death-at-different-ages

Normal developmental factors also play a role in a child's grief (**Figure 2**).[35] Children undergo important developmental changes in emotion regulation and frustration tolerance, in a range of cognitive and behavioral capacities, and in relationship needs. Neurodevelopmental states impact understanding of death and the consequent experience of grief. Developmental progress is not uniform, predictable, or even stable during childhood. Children move in and out of a given capacity in response to important social and environmental changes. In general, a major stressor, such as the loss of a member of the immediate family, can lead to use of an earlier, more learned and/or familiar emotional, cognitive, or behavioral response. This is normal and not a cause for concern. Parents need to be alert to this and prepared to support children who manifest these responses as needed. Still, it is useful to think about a general framework for where a child may be starting with respect to their cognitive and behavioral development at the time of a loss. This allows parents and other adults to meet the child where they are, to provide appropriate straight answers to questions attuned to the child's developmental capacities, and to be as available and responsive as possible to the emotional needs of a grieving child, opening spaces for dialogue when they are ready.

It is important to note that the death of a parent or the loss of a sibling can affect family dynamics. In the former, the caretaker for the child themself is lost, and in the case of a sibling loss, the entire dynamic of

the family shifts, including the role the child plays. These losses affect how parents are able to care for the surviving children when they have lost a parental partner or a child together. Grieving children may benefit from grief and trauma processing, memorializing activities to help

maintain ties to the deceased person, and future planning—along with involving their caregivers.[36]

Considerations for different types of loss

Although there are commonalities in all grief, regardless of circumstance, certain features may be more common depending on who died and how they died. It is helpful to know about ways different groups of bereaved people might be expected to commonly respond. Here we discuss just a few examples of this to highlight unique and collective aspects of grief and circumstances surrounding loss.

VETERANS AND MILITARY FAMILIES

Veterans hold a special place in our society, deserving honor and recognition for having served to protect and safeguard our country. They are likely to experience loss and grief in the course of active-duty service or in the aftermath. Even in the absence of war-related deaths, servicemembers die of other sudden violent means, including accidents, homicides, and natural disasters. In addition, death by suicide rates among Veterans are high and an area of intense focus from a policy and practice perspective.[37] Individuals whose fellow service members have died by suicide may experience intense grief that may further increase their own death by suicide risk. There are resources available specifically for Veterans and their families and service members and their families who are experiencing acute grief and loss.[38] Still, the military culture is unique in ways that can affect the experience of grief and the social response to a bereaved family. For example, the culture may make it difficult to speak out loud about losses.[39] Maintaining privacy or a “stiff upper lip” in response to emotional pain is strongly valued. It is important that service members, Veterans, and their families have access to supports that are knowledgeable about military culture surrounding loss and grief, including military notification procedures, mourning rituals, and administrative policies.

DISASTER-RELATED AND PANDEMIC-RELATED DEATHS

Tracking deaths directly or indirectly related to natural disaster, mass violence, global pandemic, or war is important so public health departments can help prevent future disaster-related deaths.[40] In the aftermath of large-scale events such as the pandemic, episodes of mass violence, or war, death toll numbers are often part of public information reporting. Many people are suddenly bereaved in a context in which their own safety also has been threatened, and this may contribute to feeling shocked, lost, anxious, and depressed.[41] In addition to the experience of the death of loved ones or community members, there may be lost property, damaged buildings, monetary loss, and confusion. Disaster behavioral health is a field that aims to help prepare for and respond to disasters and their emotional impact. Individuals with serious mental illness can be uniquely affected by disaster, compounding other challenges they may be facing.[42] In contexts of multiple deaths at once, there may be a need to first solve practical problems such as food and shelter, to help educate people about bereavement, and to provide strategies for management of intense feelings that can be overwhelming. Long term, there is increased risk of prolonged grief. In a recent meta-analysis that included 2,566 studies, 38.8 percent of people who experienced a natural disaster were considered to have prolonged grief.[43] In another study examining the long-term effect of the 2004 Indian Ocean Earthquake

and Tsunami, there were notable impacts on health and well-being for those involved, with more pronounced effects in the long term, even for those who seemed initially positively associated with psycho-social health longevity.[44] War-related deaths are another category presenting unique challenges. In one study, war-related loss for middle childhood–age and adolescent-age youth was associated with significant risk of mental health dysfunction including major depressive episodes, anxiety disorders, PTSD, and prolonged grief disorder (PGD).[45] Prolonged grief is associated with increased severity of PTSD in Veterans with combat-related PTSD.[46]

Grief related to COVID-19 pandemic deaths was an additional experience of many individuals. One study from India showed the importance of receiving supports through any modality when face-to-face help was not available.[47] Another study looked at risk factors for problematic functioning in the face of grief related to COVID-19 deaths and found that circumstantial risk factors for grief created greater dysfunction.[48] Experiencing a recent death during the health crisis of the COVID-19 pandemic resulted in more severe grief reactions, highlighting vulnerabilities of populations during large-scale health events such as a pandemic.

SUBSTANCE USE–RELATED DEATHS

Family members of individuals who die due to substance use–related overdose face numerous challenges related to social stigma, blame, and personal and family conflicts with the deceased person and even policies of medical examiners in terms of labeling the cause of death.[49] Moreover, many others besides family members are affected. Death due to adverse reaction from high-level exposure for someone with a substance use disorder can leave behind a complicated emotional picture for those surviving the loss. It has been nearly 10 years since the opioid epidemic was declared a national public health emergency in 2017, and much has been learned from the experience. For each death, there are individuals left behind who are grieving the person who died. Of the various people struggling with these losses, some of the most affected are peers and other individuals with opioid use disorder.[50] Severe grief and loss are associated with multiple exposures to overdoses, either by the person themself or adverse reactions from high-level exposure by close associates.[51] Others who have been affected by the overdoses among people with opioid use disorder are the staff who work alongside them, such as social workers.[52] In addition to grief support providers' being knowledgeable about the special needs of bereaved family members, ongoing efforts to support these individuals at an organizational level are important, as is access to mental health support services for when the grief support providers themselves are feeling emotionally overwhelmed.

SUDDEN UNEXPECTED DEATH

Sudden and unexpected deaths, such as deaths by suicide, homicide, accident, or sudden medical emergencies, are usually shocking and traumatic. As discussed, with any grieving person, it can be important to convey empathy and answer questions. In cases of sudden and unexpected death, additional support may be achieved by facilitating opportunities for loved ones to say goodbye when possible.[53] This can be especially challenging when a body is not recovered, but some means of affirming the reality of the death may be helpful to process the actual loss. After 6 months, coping styles for those survivors who were bereaved by death by suicide seem to be similar to the coping styles of survivors who experienced sudden losses.[54] However, those bereaved by death by suicide may be more likely to grapple with strong feelings

of self-blame, anger with the deceased, and feelings of being abandoned than do other bereaved people. They often feel an intense need to "become a detective," as one death by suicide–bereaved person put it—to understand why their loved one took their own life. Those bereaved by death by suicide are at higher risk for death by suicide themselves.[55] For those with a prior mental health diagnosis, there appeared to be increased avoidance and problem-focused coping. Moreover, one study of bereavement after violent and sudden death showed that avoidant coping contributed to negative outcomes and resulted in less post-traumatic growth.[56] Important to note, prolonged grief is still seen after these especially challenging deaths, likely fostered by social support, self-disclosure, and sense of belongingness, as has been found for bereavement by death by suicide.[57] Thus, violent and sudden deaths warrant a focus on early support, close attention and follow-up, and interview approaches that are not inadvertently triggering. Providing opportunities for the bereaved to guide conversation and being open to hearing their reactions, even when negative or curt. gives space for them to discuss painful topics.

PERINATAL LOSS

Perinatal loss is an area that is often shrouded in silence, with families who lose pregnancies given little to no recognition of the grief that follows. The rate of possible prolonged grief in the group experiencing stillbirths (16 percent) or neonatal deaths (16 percent) is elevated compared to recent overall estimates of bereavement (3–10 percent of deaths). Of note, the measure of prolonged grief used in this study was more restrictive than current diagnostic criteria, so rates are likely even higher. Being a woman and not having a living child were associated with the chronic pathway. Together this study showed that about 10 percent of parents experience high levels of grief during the first year after the loss. Miscarriages prior to 20 weeks of pregnancy occur in approximately 10–20 percent of pregnancies, and these data are likely an underreported figure. The aftermath of such losses can take different paths.[58] A Danish longitudinal study of parents who lost pregnancies between 14 weeks and the perinatal period identified three common patterns of grief: resilience (73 percent of respondents), recovery (17 percent), and chronic (prolonged) (10 percent).[59] Perinatal loss can be experienced as a traumatic event[60] as well as with depression and anxiety disorders.[61] PTSD also can occur because the mother's life can be threatened at the time of a stillbirth or other situations of perinatal loss. Although some cultures have superstitions about mentioning pregnancy loss until after a certain period and dictate that a person not speak of any miscarriages, other cultures have rituals to support families after perinatal loss. For example, in Japan, a Buddhist ritual ceremony called Mizuko Kuyō aims to honor the loss of the unborn soul to help the families who may be grieving.[62] Given the frequency of miscarriages and lost pregnancies, and the potential for such losses to carry a heavy emotional burden, it is important that grief-informed care take these losses and their common characteristics into account.

Prolonged grief and PGD

When a bereaved person experiences intense and unrelenting grief that impairs their functioning after they lose someone close, they may be understood as having prolonged grief (**Table 1**). Prolonged grief is associated with important mental and physical health complications including elevated rates of suicidality[63] and increased incidence of new onset or recurrence of

other health and mental health problems[64] such as substance use disorders[65] and cardiovascular disease.[66]

> "The occurrence of prolonged grief in a minority of bereaved individuals should be seen as a call for more community acceptance of grief and for universal implementation of grief-informed care in health care systems."

PGD, seen in a subset of people with prolonged grief,[67] is a condition currently included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*).[68] It is perhaps best conceptualized as a postloss stress disorder.[69] There is ongoing concern that the inclusion of PGD as a formal diagnosis inappropriately characterizes grief as a "disorder." This concern may be rooted in a misunderstanding of the impetus and concepts behind the diagnosis. For example, on the day that the new diagnosis was added to the *DSM-5-TR,* the *New York Times* weighed in with a false claim that psychiatrists want to put a time limit on grief. Others have been concerned that pathologizing[70] grief stigmatizes[71] people diagnosed with PGD, adding to their burden. Misconceptions about the time frame of grief, possible stigma associated with pathologizing, and access problems related to overmedicalization are important issues that need to be taken seriously. However, extensive research supports the inclusion of this diagnosis, as have published clinical observations.[72,73] Eventually, there was worldwide consensus on its occurrence and its inclusion in the *DSM-5-TR* as well as the ICD-11.[74] Studies have shown the efficacy of prolonged grief-targeted treatments providing important support for the need to have this diagnosis. Multiple studies showed that neither medications nor psychotherapy that are efficacious for depression were helpful for PGD.[75] A study of treatment for PTSD[76] found that co-occurring PGD was associated with worse outcomes for PTSD. On the other hand, targeted treatments developed to specifically target PGD have shown efficacy in multiple trials.[77,78,79,80,81,82,83]

It is very important that recognition of PGD not be used as a way of devaluing, criticizing, or stigmatizing bereaved people. Nor should knowledge of this disorder be interpreted as dictating how or how long a person should grieve. Rather, the occurrence of prolonged grief in a minority of bereaved individuals should be seen as a call for more community acceptance of grief and for universal implementation of grief-informed care in healthcare systems. More awareness of the grief process and PGD can contribute to prevention of prolonged grief as well as the development of more varied ways to effectively help all bereaved individuals, including those with PGD. It is important that service leaders as well as formal and informal mental health and substance use support providers know how to recognize and help people with prolonged grief whether or not it meets criteria for PGD.

Table 1: Differences Between Acute, Prolonged, and Integrated Grief

Common Grief Symptoms	Acute Grief	Integrated Grief	Prolonged Grief*
Yearning/longing/preoccupation	May be frequent, intense, and preoccupying	Come and go, frequency variable, intensity mostly attenuated though can be intense at times	Intense, persistent, and pervasive
Protest, disbelief, avoidance of reminders, intense emotional pain or numbness, sense of meaningless, loneliness	May be frequent and troubling	Infrequent, low intensity, with a minimal role in coping with the loss	Frequent, intense, persistent, and pervasive with an important role in coping with the loss
Disruption of ongoing life and sense of well-being	Expected and socially accepted	Mostly restored capacity for well-being or clearly making progress	Functioning not on track and little progress to restoring well-being

* PGD is when symptoms of prolonged grief meet *DSM-5-TR* criteria.

Screening for loss and assessment of need for support

Given that experiencing loss is universal and among the most impactful life events a person can experience, it is important for clinicians to recognize grief regardless of how, when, or why a person seeks help. This means all intake assessments should gather information about the death of anyone close as well as the bereaved person's current grief and whether it is playing an important role in their life. A general clinical mental health intake should include the person's history, strengths, and vulnerabilities. A "resilience portfolio" model[84] similar to that used by some trauma researchers can be helpful as a framework for considering strengths the individual brings to the loss experience and/or an indication of what is missing.

People vary in the degree to which they have a strong social and/or cultural identity. Nevertheless, it is important for a grief assessment to consider a bereaved person's culture, as well as the nature of their connection to that culture, when supporting them in grief. Social and cultural groups often have designated bereavement practices and rituals. These should be acknowledged, honored, and understood for a bereaved person to feel respected and comfortable. Culture, religion, family, or other social identities can be an important influence or even a determinant of grief. If possible, it is almost always most helpful when a bereaved person can work with someone who has a solid or even a deep understanding of these aspects of a bereaved person's world.

Figure 3: Possible Assessment Questions for Clinicians To Ask a Bereaved Person

- Possible assessment questions:
    - What have things been like since the death?
    - What are some of your thoughts and feelings about the loss?
    - How has your life changed?
    - Do you have religious or spiritual beliefs, and have these been comforting or not so helpful?
- Listen for how the person is feeling about themself, if there is self-criticism or self-compassion, and who is supportive or unsupportive.
- In an assessment, the clinician should stay mentally present during this discussion, be genuinely interested, listen empathically, and validate the pain without trying to reassure the bereaved person, make them feel better, fix the pain, or use the time to work through the clinician's grief.

For those seeking help with grief and those who say that grief is currently playing an important role in their life, a more extensive loss and grief assessment should follow. A detailed loss assessment is needed when grief is the focus of an intervention. This should be conducted with empathy and compassion as it will include a discussion of the circumstances of the death and the bereaved person's grief story. Most bereaved people are very interested in talking about the person who died and their life with them. Listening to their stories will help the clinician understand this relationship, what it meant to the bereaved person, and what they have lost. Then the assessment should move on to ask about what happened, how and when the person died, and how the bereaved person learned of the death. It is important for the clinician to stay mentally present during this discussion, be genuinely interested, listen empathically, and validate the pain without trying to reassure them, make them feel better, fix the pain, or use the time to work through the clinician's grief. The assessment continues to include the bereaved person's experience of the loss, a discussion of their grief, what it has been like, and how it is affecting their life (**Figure 3**).

Figure 4: Screening Instruments That Can Help Clinicians Identify Prolonged Grief When There Is Clinical Data Suggesting It May Be at Issue

The Prolonged Grief-13-Revised is a recent 13-item screening questionnaire with symptoms matching the PGD *DSM-5-TR* criteria. A score greater than 30 attained more than 1 year after the death of a loved one is a positive screen, indicating the likely occurrence of PGD. Clinicians can use this to support a clinical diagnosis or to screen prior to doing a clinical interview. This scale also can be used to estimate the intensity of early grief. A score of 20 or higher prior to a year can alert clinicians to provide grief support and/or to follow the person more closely. Using this tool serially can help show progress or lack thereof with treatment, making it a good outcome measure for clinicians treating PGD.

The Brief Grief Questionnaire is a five-item screening questionnaire. A score of 5 or higher more than 6 months after the death of a loved one is a positive screen for prolonged grief. This very simple questionnaire can serve as a good universal screening questionnaire for clinicians in general practice or in any health or mental health setting where bereaved individuals are being seen. This measure also can be used as a simple outcome measure for PGD treatments in public health settings.

The Inventory of Complicated Grief is a 19-item screening questionnaire. A score greater than 25 is a positive screen for persistent, intense, impairing grief. This instrument has been widely used in research studies to characterize people who are struggling with grief for long periods of time. This measure can be an outcome measure for prolonged grief.

A clinician will want to listen for thoughts, feelings, and behaviors that might interfere with the individual's ability to accept grief, manage emotional pain, see a future with promise, consider the story of the death, live with reminders, and/or feel a meaningful connection to the deceased. Most typically, these interfering feelings and behaviors take the form of strong feelings of disbelief, avoidance of reminders of the loss, a focus on counterfactual thinking (imagining alternative ways events leading up to the death might have prevented it, with a lot of "what ifs," and following factual paths that mentally try to change the outcome), excessive guilt, anger or disappointment in others, misunderstandings of grief, unmanageable emotional pain, or hostile or recurrent experiences of unsupportive social interactions. People who engage in excessive avoidance or have frequent troubling thoughts or feelings like these for more than a year after someone close dies might be experiencing prolonged grief and benefit from an intervention that is more targeted and active than the support for more usual grief. **Figure 4** highlights screening tools that can be useful in clinical settings when the person appears to have more prolonged grief. People with prolonged grief often recognize they are experiencing something more than usual grief and are looking for more help and support.

Interventions to support adaptation to loss

In the early bereavement period, most people turn inward, looking within themselves and to their families and close friends and others in their religious and cultural groups as they begin to grapple with the different consequences of a loss. A bereaved person who seeks support during this time needs a care provider who is a genuine, empathic listener and is nonjudgmental about the person's unique grief experience. A grief counselor, trained peer support person, or mental

health clinician who is grief literate is able to provide this kind of support. Since bereavement is a universal experience, each of us has had, or knows we will have, our own loss and grief. Care providers need to be sure to have reached a reasonable level of comfort with their own response to be fully present and supportive of a bereaved person they are serving. Support providers may have already had experiences of confronting painful, heartbreaking experiences of grief within their own lives and within other individuals, and this can get activated when working with another bereaved person.

In addition, care providers need to keep in mind the importance of the social/cultural context in which a bereaved person is grieving.[85] They need to be genuinely open to and interested in the person's experience and in their context. One way to foster this interest and openness to the importance of culture is for a provider to consider their own family, cultural, or religious background. These cultural inputs may be a part of their identity and might affect their own experience of bereavement. Taking time to consider some questions, such as those in **Figure 5,** might produce a somewhat better understanding of a person from a different culture that a provider is trying to support. Moreover, this kind of activity can open a supporting person's mind to the issues and contribute to genuine feelings of curiosity and openness to understanding a bereaved person's different experience.

Figure 5: Sample Questions To Ask To Set the Stage for Person-Centered Grief Support

- How does your background or identity affect your understanding of death or what you believe about grief?
- In what ways do people in your family/culture/religion expect people to express grief?
- How long do people in your family/culture/religion expect people to grieve?
- What kinds of rituals do people in your family, culture, and/or religious group practice when someone dies?
- Do you find these to be personally helpful?
- What else do people in your family/culture/religion do to support a person who is grieving?
- How helpful do you think this support might be?
- What kind of expectations does your family/culture/religion have about intense, preoccupying grief that interferes with other things in life?
- How personally important to you are your faith and spiritual practices, and what are some implications of this?

The basic principles to follow in supporting a bereaved person include, most important, readiness to be authentic, clear, honest, and emotionally present—without goals other than that the clinician's presence be comforting in this time of sorrow. For this to happen, a support provider should be genuinely interested in what the bereaved person has to say and curious about what the person means. The support person brings their experience and skills in validating and supporting a bereaved person; brings their knowledge to respond if the person asks questions that can possibly be answered in a helpful way; and brings gentle, respectful guidance if they believe this is a way to provide the support and comfort the person is seeking. What most people need is a person who is willing and able to be fully present with them in a

respectful, nonjudgmental, and empathic way. For some, it can be comforting to understand something more about the roots of grief and/or the general way grief emerges and evolves over time. If a clinician has had their own experience of painful loss, sharing it can be comforting to a bereaved person. If the clinician has known the person who died, talking about them can be comforting as well. However, the discussion of personal experiences should always be calibrated to the needs of the bereaved person and not those of the clinician. If the clinician is struggling with their own grief, they too may need support, but not from the person receiving services. Clinicians may wish to discuss in supervision how their grief is overlaying their response to the individual in care to help ensure that the person in therapy is getting their needs met.

PRINCIPLES OF GRIEF COUNSELING

Grief counseling can be a generic term for support for a grieving person, but it is important also to understand that it plays a formal role in the continuum of grief interventions and has a history and identified principles. In the latter half of the 20th century, researchers and clinicians became interested in death and dying.[86] Among these, Elizabeth Kubler-Ross is one of the best known. Her pioneering work brought a systematic, thoughtful, in-depth approach to the topic of death and dying. She sat with dying patients and observed that they often passed through five stages of grief after being made aware of their terminal illness. This idea was later applied to people grieving a loss. However, facing one's own death is quite different from trying to restore one's own life after a loved one's death, and the latter is unique to each person and far more complex. Although appealing as a road map for an intense chaotic experience, and popular on the internet, it is clear that a predictable "five stages" progression is not what a grieving person can usually expect.[87]

William Worden, a pioneer in grief counseling, published a book in 1982 that has been updated several times and is used worldwide to guide grief counselors.[88] The current version identifies four tasks that every mourner needs to do: (a) accept the reality of the loss intellectually and emotionally, (b) work through the pain of grief by experiencing and expressing emotional pain and not avoiding it, (c) adjust to an environment in which the deceased is missing, and (d) emotionally relocate the deceased and move on with life. This remains a helpful guide for grief counselors.

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1) Accept the reality of the loss intellectually and emotionally
2) Work through the pain of grief by experiencing and expressing emotional pain and not avoiding it
3) Adjust to an environment in which the deceased is missing
4) Emotionally relocate the deceased and move on with life

Another line of highly influential work was introduced in 1999 by social psychologists Margaret Stroebe and Henk Schut, who proposed a dual-process approach to coping with bereavement.[89] They conducted an extensive review of what was known about bereavement and grief and challenged the prevalent "grief work" model that one needs to grieve the loss, detach from the deceased, and then move on. They posited, instead, that to cope with the loss of someone close, a person needs to deal with both loss-related and restoration-related stressors more or less in tandem and in an oscillating fashion. This model was quickly and widely embraced. It

has become highly influential in the grief counseling world and is a guiding premise used in at least one evidence-based treatment.[90]

Many others have made important contributions to the field during at least a century. Among the more recent are Denis Klass and Ken Doka, each of whom drew attention to the importance of the social world. Klass emphasized the importance of “continuing bonds” with a deceased loved one, emphasizing supportive social/cultural behaviors that help support the bereaved and anchor their relationship with the deceased in the social world. These behaviors might take the form of rituals, shared stories, or physical behaviors such as bringing flowers or other offerings to the grave.[91] Doka underscored the importance of community support for grief in a different way. His highly influential work drew attention to situations in which a person’s relationship to a deceased loved one is not sanctioned by their social community. Therefore, the importance of the loss is not acknowledged, and the bereaved person is deprived of community understanding and acceptance of their grief. He labeled this as disenfranchised grief characterized by a loss’s not being acknowledged by the social world.[92] The focus on the importance of the social world in the experience and progression of grief has been highly impactful and is critical to understanding the needs of bereaved people.

The number of grief support organizations and grief therapists has increased across the country during the past half century. These agencies and practitioners generally work to help bereaved people during the early period after the loss. However, many grief counselors work with people struggling with grief at later times after the loss as well. Recently it has become clear that persistent unrelenting grief may require an approach targeting a range of processes needed to enable and foster deeper adaptation to loss.

CARING FOR THE CARETAKERS

Working with bereaved people can be especially challenging because of the universality of loss and grief. Therapist reactivity can lead to emotionality that is difficult to control and/or cognitive challenges that can interfere with a therapist’s effectiveness or even can lead to burnout or activate vicarious grief. A growing body of research is beginning to describe ways to deal with this reactivity.[93] Engaging in ongoing stress hardiness (a means of looking at stress as a growth opportunity more than a threat), cognitive reappraisal, self-compassion, mindfulness, social support, quality supervision, or physical activity can help mitigate reactivity to the stories of the person receiving services and build resilience. Therapists can focus attention on their own ability to navigate challenges, adapt to change, manage difficult emotions, persevere toward goals, and not be easily discouraged. Strengthening therapeutic skills through peer supervision, reading, and training also can build efficacy and reduce burnout.

PEER SUPPORT INTERVENTIONS FOR GRIEF AND LOSS

Peer support specialists (PSSs; also known as *recovery coaches, family support providers, youth peer workers,* and other terms) are people with lived/living experience of mental health or substance use disorders.[94] PSSs are rapidly expanding as a workforce, having grown from approximately 30,000 to 82,000 in the past decade, with nearly all states having standards including training and certification programs in place to prepare and credential PSSs.[95] PSSs provide support to people going through similar experiences, particularly related to all types of mental health and substance use challenges, which, given the universal nature of grief, includes some form of grief and loss.

PSSs perform a wide range of services to support persons with mental illness or substance use challenges, such as the following:

- Advocacy
- System navigation
- Linkage to resources
- Sharing of resources
- Social support
- Group facilitation
- Skill building
- Mentoring
- Goal setting

With the rapidly expanding peer support workforce across the United States, the landscape of where peers are employed is rapidly expanding as well. Settings where PSSs provide services include but are not limited to peer-run organizations, recovery community organizations, outpatient treatment, emergency departments, hospitals, schools/universities, and carceral settings.

Peer support services are an evidence-based practice; research shows that the use of peers can

- reduce inpatient utilization including rehospitalization rates,
- reduce the overall cost of health and behavioral health services,
- increase the use of outpatient services,
- increase hope and quality of life measures,
- increase engagement into services,
- support and increase positive outcomes linked to sustained recovery, and
- increase the whole health care.[96]

Several peer-led models for grief support have emerged across diverse settings, helping normalize grief and providing healing spaces for usual grief, prolonged grief, and PGD. Below are several peer-based interventions:

- The RIVER Model, developed by Peer Support Community Partners, offers a community-integrated framework for establishing peer grief support groups and focuses on presence, empathy, and mutual growth.
- The Compassionate Friends supports bereaved parents, grandparents, and siblings across more than 500 U.S. chapters, offering facilitated support groups grounded in shared lived experience. Research suggests bereaved parents participating in a The Compassionate Friends group were more likely to maintain a sense of positive personal change during the 1-year time span of the study.[97]
- My Grief Angels is an online grief support community providing self-guided tools, peer forums, and educational resources for people grieving loved ones.

- TAPS (Tragedy Assistance Program for Survivors) offers peer-based, trauma-informed support for military families grieving loved ones' deaths, including a variety of programs such as its annual National Military Survivor Seminar and Good Grief Camp as well as a large peer mentor program.

Peer support services also can be effectively delivered through digital platforms, enhancing access for rural, incarcerated, or socially isolated individuals.[98] This aligns with the expansion of telehealth grief services and the proliferation of online peer networks like My Grief Angels and other grief support groups.

Despite these examples of peer-based support models, professional peer support workers offer a largely untapped workforce for providing grief support services. According to a 2023 report to Congress by the Office of the Assistant Secretary for Planning and Evaluation about grief in the United States, only 41 percent of people were satisfied with their spiritual leaders in providing grief support, the highest level of dissatisfaction among various sources of social support.[99] In addition to this, only 40–52 percent expressed satisfaction with support from family, friends, or coworkers. The highest satisfaction rating was the support received from pets or animals, at 89 percent.[100]

Social connection is vital to substance use recovery, mental wellness, and grief support. Yet the Surgeon General's Advisory on Healing Effects of Social Connection and Community indicated that there was a 16 percent decrease in social network size from 2019 to 2020 and a 50 percent increase in the percentage of Americans having three or fewer friends in their circles since 1990.[101] Given the rising national burden of bereavement and need for better grief services, as well as risks for loneliness and isolation, peer support for grief and loss with an evidence-based framework could help fill this gap.

Grief peer support might be especially helpful after sudden, traumatic, or death by suicide–related losses.[102] The need for these services is exacerbated due to the large death by suicide, overdose, and early mortality death rates.[103] Unexpected and untimely kinds of deaths can be especially difficult to navigate; the presence of a peer support provider can provide mutual understanding, and the shared experience can mitigate isolation and emotional distress.[104] A systematic review suggests peer support appears to be especially valuable for survivors of death by suicide, a result that may be related to the stigma and lack of support from family and friends that are experienced by many survivors of death by suicide.[105] Understanding these and other sudden, unexpected, violent deaths, such as perinatal loss, death of a child, or death of a marital partner, should be prioritized in training for certified peer supporters and peer-run organizations in order to recognize risks and know when to refer for professional or other ancillary supports. Often certified peers can mitigate intensity of symptoms and help problem solve challenges, but they need to know when to raise the alarm, when to support, and when to do both. This is the heart of grief-informed peer support as described by the G.R.I.E.F. model below.

SAMHSA 2024 CFRI Report on Peer Recovery Support Services provides a broader systems-level rationale for expanding peer interventions that also can lend support for grief peer support expansion.[106] Although recovery from grief is not an aim of peer or clinical service providers, peer recovery support principles can be applicable to grief support, where individuals often experience deep emotional pain with or without meeting formal diagnostic thresholds for

treatment. PSSs are also increasingly utilized in nonclinical environments, including schools, workplaces, communities, and faith-based organizations, and are provided by individuals with lived experience, including family members.[107] These settings represent critical access points for individuals who may not pursue formal mental health treatment but experience little support for their grief, particularly following community trauma, incarceration, or substance-related loss. With proper grief-informed training and support, PSSs are uniquely positioned to more effectively support bereaved individuals.

ROLE OF PEER SUPPORT

The peer role in grief support services is to recognize and understand the signs of acute, continuing, and prolonged grief, as well as possible PGD; to be educated and supported in how to respond to a bereaved individual; and to know when to refer for additional clinical supports. Peer support providers need to know what to look for, common myths and facts about grief, and pitfalls to avoid, and they need to understand that every grief experience is unique. An exploratory, qualitative study published in 2018 includes key ingredients for successful peer support programs for grief, including suggestions for how peers can encourage evidence-based treatment for grief while staying within their scope.[108] According to the results, this includes a close partnership of peers with clinical mental healthcare providers, which can facilitate referrals as needed.

SKILLS TRAINING FOR PEER SUPPORTERS

There is a critical need for grief education across the certified peer support profession, as there is across professional care systems as a whole. Most graduate-level clinical programs provide limited training on grief and bereavement, which leaves many mental health providers underprepared to provide appropriate and effective grief support.[109] This is also true for certified peer supporters and other nonclinical supporters.

> "Training and education on grief and bereavement in graduate school programs is often insufficient," resulting in "practitioners ill-equipped to identify and treat PGD"
>
> – *Overview of Bereavement and Grief Services in the United States, p. 25*

Certified peers who have dealt with their own challenges of loss are uniquely positioned to provide grief peer support from a space of empathy and encouragement. Some of the caveats noted above regarding clinicians who are dealing with their own grief can apply to peers as well in that the focus of support services needs to be on the identified person receiving services, and PSSs may need separate supports themselves. Nevertheless, leveraging direct lived/living experience is precisely what positions certified peers to provide support. However, it is important for the PSS community to understand that everyone grieves in their own way. This requires being clear about what "grief-informed peer support" means as well as fostering best practices in this space. This also means ensuring that peers are positioned to be helpful to others while being safe to themselves. Having the right constructs and protective factors in place that maintain supportive environments for all persons involved is of the utmost importance.

Grief literacy training for peer support specialists should prioritize skills such as the following:

- Recognizing commonalities in grief along with the unique way each bereaved person grieves each loss
- Recognizing grief in oneself and learning when and how to share one's own grief experiences (i.e., when to share, when not to share, how much to share, how much not to share)
- Recognizing cultural considerations for the bereaved individual's potential mourning rituals
- Discussing and normalizing grief and supporting the process of the bereaved individual's adaptation to their loss
- Recognizing usual grief versus prolonged grief descriptors
- Understanding why, when, and how to refer an individual for clinical care

In peer support contexts, foundational training must prioritize grief literacy. Such training should include the following knowledge points: understanding of the variety of normal grief responses, signs of prolonged grief, empathetic communication skills needed to share this information effectively with the bereaved individual, information about mental health consequences of bereavement with referral thresholds for clinical care, and awareness of any cultural considerations for mourning practices.

For certified PSSs to be "grief literate," they should feel confident offering social and emotional support to bereaved people and knowing when clinical care might be necessary. According to the NASMHPD Research Institute's State Profiles report, in 2023, 44 states supported the use of certified peer support workers, with each state's determining its own unique set of competencies and standards for the peer services being delivered.[110] Therefore, state leaders can play an integral role in providing grief support skills training to their certified peer support workforce. Peer training and curriculum development for a grief-informed peer workforce should be grounded in the Substance Abuse and Mental Health Services Administration's dimensions of wellness and peer competencies and the National Association of Peer Supporters core values to ensure fidelity to the peer role and goals of the bereaved individual.

FAITH AND SPIRITUAL PRACTICES AND IMPLICATIONS

Faith and spiritual communities have long been places where individuals turn for meaning, comfort, and connection after the death of loved ones. Limitations in accessibility of grief support in clinical settings opens the door for trusted community actors, such as faith institutions, to help fill gaps. Faith-based organizations can provide grief support that is culturally resonant and emotionally accessible to the communities in which they serve.

GriefShare is a nondenominational ministry that provides grief support groups to 20,000 faith institutions worldwide. Each weekly GriefShare group, whether in person or online, provides a 30-minute video featuring experts on grief-related topics, followed by a discussion among the group about what was discussed and what is going on in their lives. Featured topics include loneliness, fear, anger, regrets, relationships, and hope. Research suggests GriefShare, with both social support and spiritual connections, can be helpful in bereavement.[111] However,

according to GriefShare after an implementation effort of GriefShare into an Adventist Church in Atlanta, the 12-week program was not sufficient due to the constant need for grief ministry, which led to integrating grief support into the life of the church as a universal practice.[112]

Grief literacy may be especially important in faith and spiritual leaders. Survey data presented in the Office of the Assistant Secretary for Planning and Evaluation's report cited above showed that satisfaction ratings for spiritual leaders in proving grief support were low.[113] This dissatisfaction likely reflects a deficit in grief-literacy training among faith leaders. PSSs trained in spiritual literacy can help to bridge the gap between pastoral care and grief support, including by collaborating with grief-literate chaplains, clergy, and spiritual care providers to cofacilitate grief support groups. Broadening exposure to the concepts outlined below about grief-informed services could help more people receive and give needed supports.

INTERVENTIONS FOR PROLONGED GRIEF

As noted above, the phrase "prolonged grief" may be confusing and imply to some that most grief is not prolonged. However, this is not the case. Most grief does not get resolved quickly (or at all) or completed, especially after death of a much-loved person. Prolonged grief in the technical and clinical sense is not about the continuation of grief for a prolonged period of time or just grief that is long-lasting. Instead, this phenomenon, which in its most severe form would meet *DSM-5-TR* criteria for PGD, resembles a postloss stress disorder, similar to PTSD, in which something is interfering with one's ability to integrate information about a troubling event and make peace with it (see **Table 1** regarding prolonged grief and PGD). This is an important misconception because it can cause an intervention to get off on the wrong foot if it seems as though grief is a "pathology" that must be fixed.

Intervention for prolonged grief, like grief support at any time, needs to honor and respect grief as the form love takes after someone close dies. This can be difficult for a bereaved person to understand when they are experiencing intense preoccupying pain, so it is especially important that a person providing an intervention not reinforce the idea that grief is something to be rid of or to simply shed. Normalizing and destigmatizing grief is a common component of evidence-based treatment for prolonged grief and PGD. We briefly discuss these and other principles and procedures used in treatments with clear and replicated positive outcomes. In addition, there are a group of interventions that have been thoughtfully constructed, described, and used by therapists but not yet tested in adequately conducted clinical trials. We will briefly describe these.

PRINCIPLES OF EVIDENCE-BASED PROLONGED GRIEF THERAPY

The first evidence-based treatment for prolonged grief appeared in 2005, long before the disorder was formalized. Following publication of this integrated therapy, several groups developed manualized cognitive behavioral treatments.[114] Prolonged grief therapy (PGT) is rooted in a simple evidence-informed model of adaptation to loss, as entailing acceptance of the reality of the loss and restoration of the capacity for well-being.[115] Initially named traumatic grief therapy,[116] then complicated grief therapy,[117] and now prolonged grief therapy,[118] it is the only one of the existing therapies that focuses intensively on restoration of capacity for well-being, including work with aspirational goals and strengthening of relationships from the beginning of the work. This paper further describes this treatment, highlighting its commonalities with other

efficacy-tested cognitive behavioral therapy models, and then reviews other promising untested approaches.

EVIDENCE-BASED PGD TREATMENT

PGT focuses on a set of “healing milestones” organized around information and experiences designed to help people with prolonged grief accept the reality of their loss and restore their capacity for well-being.[119] PGT considers adaptation to be a learning process entailing both cognitive and experiential processes with both loss and restoration-focused elements. The treatment seeks to foster these learning processes rather than to lower grief frequency or intensity. Accepting the loss entails dealing with its permanence; the corresponding permanence of grief; the changed relationship to the deceased; and more individualized changes in personal, family, and social experiences. Restoration of well-being targets capacity to thrive as described in self-determination theory,[120] including autonomy, competence, and relatedness. In working through six healing milestones,[121] clinicians also help individuals identify and address impediments that derail this process. Cognitive behavioral treatments also posit a process of moving forward naturally after a loss. These approaches, however, focus on removing impediments to this process, which entails correction of maladaptive cognitions and dysfunctional behaviors.[122]

Any prolonged grief treatment needs to be implemented within a framework of validation, support, and guidance, following the principles of the G.R.I.E.F. model introduced and described below. Therapists share information about grief and adaptation to loss and help individuals identify milestones associated with these. Therapy is undertaken from a position of presence (or active listening) empathy and nonjudgmental acceptance of grief and with validation of individual bereavement-related experiences. An ongoing focus on restoration of the capacity for wellness is recommended. This might include strengthening relationships with people who are still alive and reducing isolation. Therapists also need to be alert to impediments, seeking to identify and address these. Common impediments to adaptation include experiential and behavioral avoidance, ruminative self-blaming, or angry thought and/or alternative imagined scenarios: the “if onlys” and “what-ifs.”

In PGT, healing milestones are addressed sequentially, beginning with encouraging those being served to get to know their grief and to accept it without judging it or feeling judged because of it. They are encouraged to monitor their grief using a daily diary to learn what activates their grief, the different forms it takes when activated, the kinds of things that might further stoke the fire, and what might soothe strong grief emotions. Simple daily monitoring of high and low grief levels can help do all of this and also help people with prolonged grief see that grief varies during the course of most days. Though people with prolonged grief may be reluctant to start this exercise, when they try it, they often find it is more interesting than they expected.

Therapists then move to suggest that individuals make plans for simple rewarding daily activities, and they introduce the idea of meaningful goals for the future. Even early in the treatment, many people are surprisingly able to do an exercise that opens a door to possibilities for an inviting future. Meeting with a close family member or friend is another part of restoring the capacity for wellness. The purpose of this meeting is to introduce support people to tenets of grief literacy, reduce their isolation, and strengthen their support. For a person with prolonged grief, this meeting often restores a frayed bond with someone close. Then, within this more

hopeful and supportive context, the therapist introduces the idea of revisiting the story of the death, which can serve to help people learn to accept the finality of the loss and to recognize and deal with troubling thoughts and feelings. Doing so enables the loss and grief to live more comfortably and less obtrusively in their lives. Similarly, gradual confrontation with avoided reminders of their losses can help people find ways to live more comfortably in a world of absence. Encouragement to connect with memories of the people who died is introduced at the end of the treatment, in the context of acceptance of death and the continuing absence of their people. Revisiting memories in this context can engender a comforting sense of ongoing connection to the deceased people.

ADDITIONAL INTERVENTIONS FOR PROLONGED GRIEF

Although the methods are not well studied, some experienced grief therapists use a variety of methods such as narrative therapy,[123] "meaning-making" therapy,[124] eye movement desensitization and reprocessing,[125] tapping,[126] music and art therapy,[127, 128] or nature therapy.[129] Although these have not been tested for efficacy, case reports and testimonials of therapists and those being served support their possible utility and helpfulness. Any theoretically based approach that follows the tenets of the G.R.I.E.F. framework has a reasonable chance of being helpful. The single most important way to help a person move through grief is to listen. Therapists from a wide range of backgrounds can be helpful if they are truly present and truly curious about the person's experience and refrain from trying too hard to change what the person is experiencing. Some individuals prefer this to any other approach. However, whether using tested or untested treatments, it is important to conduct periodic assessments to confirm effectiveness of the intervention. In addition, therapists should always be aware of the potential importance of a bereaved person's social, cultural, and religious affiliations and should consider when and where a person might receive family, clergy, or peer support or other community resources that can be helpful in the process of adapting to a painful loss.

The G.R.I.E.F. framework

A large body of research resulted in the concept of trauma-informed care, but many scholars point to a 2001 publication edited by Maxine Harris and Roger Fallot titled *Using Trauma Theory to Design Service Systems* as pivotal in its development. In that book they articulate the following:

> *Systems serve survivors of childhood trauma without treating them for the consequences of that trauma; more significant, systems serve individuals without even being aware of the trauma that occurred. This lack of awareness can result in failures to make appropriate referrals for trauma services. It can also result in inadvertent retraumatization when a service system's usual operating procedures trigger a reemergence or an exacerbation of trauma symptoms.* (p. 3)[130]

The idea that trauma exposure is a very common, if not universal, experience that affects some segments of the population more frequently and at earlier ages than others led to the recognition that trauma may be contributing importantly to the symptom picture of individuals seeking mental health and other health-related services. Harris and Fallot asserted that being trauma informed was necessary for adequate health care since systems were already serving

trauma survivors, often without any awareness of their past trauma. This lack of awareness would lead to inadequate care if there were failure of recognition that presenting symptoms were trauma related. Furthermore, if an individual were not appropriately diagnosed and/or connected to services that could identify and address trauma sequelae, the individual may in turn become further traumatized. The authors identified specific elements required for a trauma-informed system of care:

1. Administrative commitment to change
2. Universal screening
3. Training and education
4. Hiring practices
5. Review of policies and procedures

The authors also described that a trauma-informed system might come about by (a) understanding trauma, (b) understanding the "consumer survivor," (c) understanding services, and (d) understanding the service relationship.

"She wrote in a world in which mourning was still recognized, allowed, not hidden from view." (Reflecting on the etiquette surrounding mourning outlined by Emily Post in 1922.)

- *Joan Didion, The Year of Magical Thinking*

One can argue that a dynamic related to loss and grief similarly necessitates a systemic approach incorporating grief and grief experiences in the design of service systems. Loss of a loved one has overlapping features with exposure to trauma, even in cases wherein the loss does not meet current official clinical definitions of trauma.

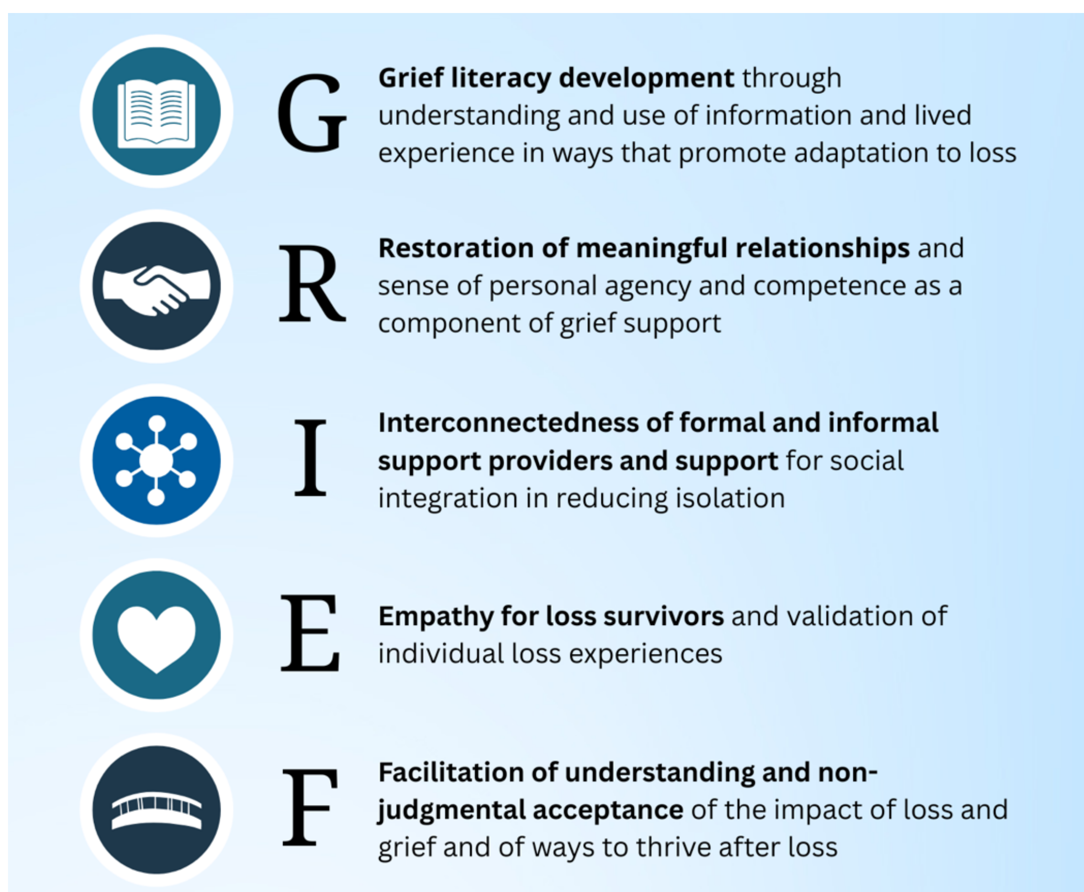
In the United States, the "privatization" of grief has become increasingly expected and the norm.[131] A consequence of this development is that a grieving individual may be expected to need little time to "move on" or "get over" a loss. Friends and neighbors may engage in a rush to send over a casserole after a neighbor has experienced the death of a loved one, but for many bereaved, the casseroles will stop coming well before their grief has abated. Moreover, the bereaved often describe a sense of isolation, finding that others do not feel comfortable talking about the deceased person or hearing about the family's grief. Religious rituals such as wakes, shivas, funeral practices, and other memorial opportunities have an important role for people of faith, but if one does not subscribe to a particular faith, there may be few social occasions to share and process the loss. In a report to Congress in 2023, the Office of the Assistant Secretary for Planning and Evaluation highlighted the need to enhance systemic approaches to grief support, as was highlighted in the aftermath of the COVID-19 pandemic, when there was an increased moment of shared and collective grief.[132] In a service delivery system for mental health and substance use services, recognition of the impact of bereavement and the intricacies and variances in the grief experience is often minimal. There may be a focus on "anniversary reactions" or immediate responses to loss, but other than that, the person being served or the worker experiencing a loss must chug on with "services as usual."

Death rituals vary considerably around the world. Sky burials in Tibet include leaving the body of the departed outside to be eaten by birds and other animals to allow the soul to depart and celebrate the circle of life. *Famadihana* in Madagascar entails the opening of tombs and rewrapping of remains every few years to help move the spirits toward the afterlife. In Nordic countries, water is often involved in rituals for the dead, while in parts of India, the deceased may be paraded through town dressed in colorful garb to then be placed on a pyre after visiting the Ganges River. Traditions in Mexico include parades and altars to reflect on the deceased every year during the Day of the Dead. Notably, due to the cultural heterogeneity of the American population, there aren't death rituals that are uniquely "American."

Given the increasing recognition of the profound impact of loss and grief on people's lives, there is a need for mental health and substance use system leaders, providers of mental health and substance use services, and partners across all healthcare systems to make a more concerted and organized effort to place grief in the forefront of policy and services for people with serious mental illness, youth with serious emotional disturbances, individuals with intellectual and developmental disabilities, and those with substance use disorders. Grief-informed services, just like trauma-informed services, are needed to ensure that loss and grief are understood and appropriately included in system planning and services delivery. This means systems also need to attend to staff and leaders who themselves may be experiencing grief. Policies and practices are required to ensure that care systems do not shroud bereavement and grief in secrecy but allow space for it to be recognized and for grieving individuals, as well as staff and leaders, to be meaningfully and appropriately supported.

A grief-informed practice and services framework can provide a standard, organized approach to grief-informed services. The required elements outlined in the trauma-informed system and the related principles can be mapped onto the G.R.I.E.F. framework, with leaders setting an intention to commit to thinking within this framework as a corollary to trauma-informed care. Such an approach can equip everyday service providers with knowledge and skills to walk alongside individuals experiencing loss; to gain their trust; and to validate, support, and guide them on their grief journey. Informed in part by trauma-informed care, evidence-based interventions, peer bereavement support experience and values, religious and spiritual support, and family systems, the G.R.I.E.F. framework below outlines five core elements to guide the development and implementation of high-quality grief-informed services throughout the community and within clinical service systems. Setting an intention by leaders and administrators is an overarching expectation to help this framework shape services. To that end, the following outlines the required elements for a grief-informed service system.

A FRAMEWORK FOR G.R.I.E.F.-INFORMED SERVICES IN PEER, FAMILY, AND MENTAL HEALTH SERVICE-DELIVERY SETTINGS



Mental health services have a long way to go to meet the needs of bereaved persons in the country. Leadership commitment will require leaders first and foremost to be aware of the G.R.I.E.F. framework and its place in the overall system, including grief support programming for individuals with serious mental illness and serious emotional disorders. Leaders could then ensure that staff are grief literate through intentional dissemination of information about loss and grief and the G.R.I.E.F. framework, encouraging participation with opportunities for feedback and refinements. Enlisting staff to help further disseminate the G.R.I.E.F. framework along with implementing its core features also will be important. Workforce development and training on the G.R.I.E.F. framework would be another priority area for leaders.

Given the complexity of grief, the varied ways loss is recognized and supported across cultures, and how the United States has taken on a view that grief is a private affair, it is important that there be efforts to implement G.R.I.E.F. as an organizing framework that will bring light to the experiences of loss (**Table 2**)

Table 2: G.R.I.E.F. Framework Implementation

Letter	Principles of Optimal Grief-Informed Care	Peers, Family, Workplace (Nonclinical)	Social Work, Mental Health, and Health Settings (Clinical)
G	Grief literacy expansion through education and sharing of lived experience	• Guiding resource navigation: Connect individuals with grief support groups and treatment professionals. • Recognizing and addressing harmful coping: Recognize risks like substance misuse or self-isolation and provide support for healthy coping skills. • Recognizing prolonged grief as different from enduring or long-lasting grief: Identify signs of usual and even longer-lasting grief compared to complicated grief and provide guidance toward additional support.	• Give ongoing attention to one's own grief literacy, provide psychoeducation and literacy resources to loss survivors, and encourage sharing of lived experience. • Recognizing and addressing impediments to adaptation and encouraging effective coping: Identify "derailers" and provide appropriate intervention. • Recognizing prolonged grief: Aim to build one's own adequate knowledge of PGD and its treatment; provide psychoeducation about PGD, and provide evidence-based treatment or offer treatment referrals.
R	Restoration of meaningful relationships and sense of personal agency and competence as a component of grief support	• Providing practical coping support: Encourage self-care, mindfulness, and grounding exercises to foster more resilience to connect with others. • Encouraging meaning making: Support ways to identify, understand, and honor loss through service and storytelling, utilizing one's own lived experience when appropriate and sharing connections. • Guiding through transitions: Provide support in rebuilding relationships, leaning into personal lived experience when appropriate. • Balancing emotional pain and respite: Support the balance between being with others and being alone.	• Coping and adapting support: Encourage self-compassion, mindfulness, and strategies for managing emotions to help foster the ability to connect socially. • Recognizing strengths and resilience: Support individuals in reconnecting meaningfully with others, including providing assistance to them. • Honoring the person who died: Support rituals and memory-based practices that may foster conversation and dialogue. • Supporting patients in restoring their capacity to thrive: Help restore a sense of belonging, community, connectedness, and competence. • Balancing: Assist individuals in privacy, sharing, and envisioning of the future with greater strength in relationships.

I	Interconnectedness of formal and informal support providers and support for social integration in reducing isolation	• Fostering community support: Encourage participation in peer-led groups. • Reducing isolation: Help reconnect grieving individuals with social support systems. • Collaborating with other systems: Engage with justice, education, and healthcare systems.	• Encouraging patients to participate in community groups: Encourage social or religious group participation. • Reducing isolation: Explore history of social participation, and discuss reconnection strategies. • Advocating for systemic support: Encourage participation in social activism and policy advocacy.
E	Empathy for loss survivors and validation of individual loss experiences	• Holding space: Acknowledge grief as unique and validate its nonlinear nature. • Listening actively: Allow individuals to express their emotions freely without interruption or advice. • Validating feelings and experiences: Recognize and affirm all expressions of grief; recognize and validate helpful and unhelpful social experiences.	• Holding space for loss and grief: Recognize the importance of loss, and acknowledge grief. • Listening actively, being fully present: Listen closely to verbal and nonverbal communication. • Validating and accepting grief: Affirm grief expressions without attempting to "fix" them; be open to listening and to validating painful and helpful interactions with others.
F	Facilitation of understanding and nonjudgmental acceptance of the impact of loss and grief and of ways to thrive after loss	• Sharing lived experience (when appropriate): Offer personal experiences while keeping focus on the grieving individual. • Demonstrating cultural and spiritual sensitivity: Honor diverse grief expressions and healing practices. • Being present: Provide consistent, nonjudgmental emotional support.	• Honoring each grief experience and facilitating acceptance and understanding: Demonstrate genuine interest in personal loss and grief experiences. • Demonstrating cultural and spiritual sensitivity: Solicit and validate diverse cultural and spiritual grief practices. • Creating an accepting, nonjudgmental environment: Accept grief as complex and variable.

IMPLEMENTATION OF G.R.I.E.F.-INFORMED SERVICES

To move from traditional services that keep grief hovering in the background to grief-informed services that move grief more into the foreground will take intentional efforts to implement the framework's overarching elements. Strategies to do this could include the following:

- Build interdisciplinary grief-informed care teams that include peers, clinical staff, and spiritual leaders to develop grief-informed care models
- Promote inclusion of grief-informed peer roles in supervision within hospital crisis services and faith centers to ensure proper supervision and self-care practices are adhered to and to ensure reduction in role drifts
- Leverage widespread co-location in places such as churches, schools, workplaces, hospitals, emergency rooms, court systems, and other community settings when and where possible
- Screen for loss and grief in clinical settings
- Create referral pathways to grief interventions, including PGT if needed
- Build a workforce through recruitment, development, and training at all levels to target universal grief literacy
- Evaluate and monitor systemic grief literacy and ongoing responsiveness to the needs of grieving individuals and staff

With regard to serving the staff in addition to the people in care, it is important for leaders to adopt grief-informed attitudes to help advance modern policies along the lines of the articulated G.R.I.E.F. framework. An example is the challenge of bereavement leave. All too often in the United States, bereavement policies allow for an average of 3–5 days of leave, after which an employee is required to use sick time, vacation time, or personal time if they need additional time off. The organization Option B is an example of an advocacy and support resource for grievers, inspired by Sheryl Sandberg, former CEO of Meta, after the sudden death of her husband while they were on vacation. By shifting how leave is taken for bereavement, employees have greater access to more acceptance of the impact of their loss, the possibility of restoring their capacity for wellness sooner, and a sense of community understanding and social connectedness despite their loss.

In addition to bereavement leave, more and more organizations are building in wellness activities to enhance morale and staff retention. For example, in Michigan, state agencies are working together under the leadership of the Department of Labor and Economic Opportunity to cultivate mental health in the workplace. Local employee assistance programs also often offer bereavement resources and wellness activities for general supports, and leaders should engage in efforts to understand what is offered and ensure resources are maximally available to staff. Personal grief support may be available through employee assistance programs or in the local community, and human resources personnel would do well to have a list of specific groups, agencies, grief therapists, and counselors to give to staff who may be interested in more professional counseling. There are myriad opportunities for grievers across the country to engage with supports and even specialized efforts for particular populations such as Veterans, parents who have lost children, seniors, and youth.[133]

It is important for organizations to take stock and continuously improve in all dimensions of the G.R.I.E.F. framework. A grief-informed system would do well to periodically survey employees as well as individuals receiving services to ensure that all aspects of the system are delivering grief supports in consistent and effective ways.

Conclusion

There is no right or wrong way to grieve and no time frame or expected landmarks to “get over” a loss. It is important that bereaved people as well as their friends, families, and the community at large understand and accept a grieving person without judgment. This is true for those providing informal and formal interventions for people with acute and prolonged grief, including PGD. A person experiencing prolonged grief is having difficulty accepting the absence of their person and/or restoring their own capacity to thrive. In this context, their grief, as always, is the natural response to their experience of loss. At the same time, to date there has been a significant body of research to understand prolonged grief, and there are evidence-based practices that can help individuals who have prolonged grief or PGD but have not received proper treatment. This paper provides specific background to these important issues.

Beyond the advances in science, there is a growing recognition that grief, which may or may not come about through an actual trauma, deserves its own attention. Through the current understanding of the importance of recognizing and addressing grief in a thoughtful manner, it is important to advocate that grief should be brought out of private back rooms and allowed into the public’s view. In doing so, service providers can increase people’s ability to address the human experience of grief and facilitate further help for individuals suffering from more prolonged grief. In addition, staff and leaders within mental health service systems will be better equipped to support those in care if their own grief needs are addressed. In this way, the outline for a G.R.I.E.F.-informed service framework can serve as a roadmap for state service leaders and policymakers.

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