

The Neurobiology of Grief and Loss

Somatic and Experiential Treatment Interventions

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Workshop Roadmap

- How am I experiencing my grief?
- How can I grieve this loss?
- What have I lost?

Key Terms in Grief

Why These Terms Are Important to Understand

1. People frequently have unrecognized and acknowledged losses.
2. People often fail to understand what grief is and recognize it.
3. There can be long-term adverse outcomes of ungrieved losses.

Three Terms at a Glance

Term	What It Is	Where It Lives	Example
Bereavement	The objective circumstance of the loss	The situation surrounding the person	"She has been bereaved for six months."
Grief	The internal response to the loss	Inside the person — thoughts, feelings, body, spirit	"He feels a wave of grief passing her chair."
Mourning / Grieving	The active, external expression of grief	Between the person and the world	"They mourned together by going back to the accident scene, sharing stories and tears."

A simple frame: bereavement is the fact, grief is the feeling, mourning is what you do with the feelings.

There Are Different Processes Going On in Mourning

1. Revising the attachment and psychosocial ties binding the mourner to the loved one (not detachment!).
2. Adaptation to the loss — internal focus: who am I now?
3. Adaptation to new world — external focus: how do others see me?

Grief Is Involuntary, Mourning Is a Choice

Grief just happens.

It arrives on its own timeline, often triggered by things no one can predict — a song, a smell, an empty chair.

Mourning requires active participation.

A person can suppress, delay, or avoid expressing grief outwardly, even while it continues underneath.

A helper's task is never to "fix" or take away grief.

It's to create safety for mourning — and explore the unique needs of the mourner for the active expression of grief to facilitate healing.

Mourning Is Active Work — Worden's Four Tasks of Mourning

1. Accept the reality

of the loss.

2. Process the pain

of grief.

3. Adjust to a world

without the deceased.

4. Find an enduring connection

while moving forward.

Tasks, not stages — there is no fixed order, and any task can be revisited. “Mourning... requires commitment and active participation on the part of the person who is grieving.” Source: J. William Worden, *Grief Counseling and Grief Therapy*.

“The Five Stages” Were Never About Grief the Loss of Another Person

Kübler-Ross's five stages were about dying, not bereavement.

Denial, anger, bargaining, depression, and acceptance described the experience of terminally ill patients facing their own death — from *On Death and Dying* (1969) — not the grief of survivors.

No evidence of fixed, sequential stages in bereaved grief.

Grief researchers have not found that people move through set stages in order — the idea was extended to bereavement well beyond what the original research supported.

Treating stages as a checklist can harm, not help.

It can make a normally grieving person feel like they're “doing it wrong” for skipping a stage, moving out of order, or lingering too long in one.

Better fit for this curriculum: Bonanno's trajectories and the Dual Process Model's oscillation — grief has patterns, not a script.

Disenfranchised Grief: When Grief Isn't Allowed to Be Mourned

“Grief that results from a loss that is not — or cannot be — openly acknowledged, socially validated, or publicly mourned.”
— Kenneth Doka (1989)

Category	Examples
The relationship isn't recognized	An ex-spouse, an affair partner, a close friend, a cohabiting partner not seen as “real” family.
The loss itself isn't recognized	Miscarriage, pet loss, ambiguous loss, the losses of dementia before death occurs.
The griever is excluded	Children, people with intellectual disabilities, the very elderly — often judged unable to grieve “properly.”
The circumstances are stigmatized	Suicide, overdose, AIDS-related death, incarceration — grief complicated by shame or silence.

Disenfranchised grief doesn't disappear without mourning — it goes underground. Naming and validating an unrecognized loss is often the first act of care a helper can offer.

Prolonged Grief Disorder (DSM-5-TR)

Added to the DSM-5-TR in 2022. Requires at least 12 months since the loss for adults (6 months for children and adolescents).

Core features: intense yearning or preoccupation with the deceased, nearly every day, along with identity disturbance, loss of meaning, and functional impairment exceeding cultural norms.

The distinction: ordinary grief gradually eases over time; prolonged grief stays intense and impairing well beyond what's typical.

Callback: this maps onto Bonanno's “Chronic Grief” trajectory — sustained high distress that does not resolve. Source: American Psychiatric Association, *DSM-5-TR* (2022).

The Neurobiology of Grief

Defining Neurobiology

A branch of the life sciences that deals with the anatomy, physiology, and pathology of the nervous system.

- Terms like neuroscience, brain science, and neurobiology are all used to describe this field.
- We think of it as how the brain works — but it is broader.
- How the brain works in conjunction with the nervous system — which interacts with every system of the human body.

Neurobiology

- New advances in understanding neurobiology help us expand and explain grief better.
- We now see how grief is a “whole person” experience impacting every part of the person — body, mind, and spirit.

Recommended Resources

- The Grieving Brain: The Surprising Science of How We Learn From Love and Loss — Mary-Frances O'Connor, Ph.D.
- The Grieving Body: How the Stress of Loss Can Be an Opportunity for Healing — Mary-Frances O'Connor, Ph.D.

The Grieving Brain: Why We Keep Reaching for Who's Gone

Yearning for someone who has died correlates with activity in the nucleus accumbens — a core node of the brain's reward network.

In neuroimaging studies, people who report the most yearning for a deceased loved one also show the most activation in the nucleus accumbens — the same reward circuitry involved in attachment and craving.

Psychologist Mary-Frances O'Connor describes grief through a “gone-but-also-everlasting” model: the brain's semantic knowledge (“they are gone”) conflicts with deep, implicit attachment learning (“they still exist, I can find them”).

Grieving, in this view, is a form of learning — the brain gradually updates its predictions about the world through time and lived experience, not through willpower or information alone.

Source: Mary-Frances O'Connor, PhD, University of Arizona — The Grieving Brain (2022).

The Nervous System's Grief Response

Grief doesn't only move through thoughts and feelings — it moves through the nervous system, in waves of activation and collapse.

Three States, One Nervous System (Polyvagal-Informed Framing)

1. Ventral Vagal — Safety

Calm, connected, able to think clearly and be present with others. The state co-regulation and the ministry of presence aim to restore.

2. Sympathetic — Mobilization

Fight, flight, restless searching. In grief, this often shows up as the “protest” and yearning phase — agitation, urgency, difficulty sitting still.

3. Dorsal Vagal — Shutdown

Collapse, numbness, disconnection. In grief, this often shows up as despair, heaviness, and withdrawal — the body's last-resort brake.

A note on the science: the specific physiological mechanisms Porges proposed for this model have been publicly challenged by a group of autonomic-nervous-system researchers as of 2025–2026, with Porges offering a scholarly rebuttal — this remains an active, unresolved debate. Whatever the outcome, the clinical tools this framework has popularized (breathwork, grounding, co-regulation) hold up on their own evidence.

Why Grief Can Feel Like It's Still Happening

The same missing timestamp shows up in unprocessed grief. A loss that was sudden, violent, or otherwise overwhelming can be stored the way any trauma is — as vivid, undated sensory fragments rather than a narrated, “this happened” memory. That's part of why some griever describe the moment of the death, or the goodbye, as something that still ambushes them years later with the same present-tense intensity as day one.

1. Listen for present-tense language.

“I'm standing in the doorway and I see him” (rather than “I remember standing...”) can signal a memory still stored without its contextual tag — not just a figure of speech.

2. Gently support the narrative, not premature closure.

Helping someone place details in time and sequence — without rushing them toward “moving on” — echoes what CPT and PE do clinically: building the dated, verbal account alongside the raw sensory one.

3. This isn't the same as the ongoing bond.

The yearning and continued attachment described elsewhere in this curriculum (O'Connor's “gone but everlasting” model) is a separate, healthy thread from an untimestamped traumatic memory — the goal isn't to end the bond, only to help the memory of the loss itself settle into the past.

1. Present-tense storytelling is data, not just style.

When someone narrates a painful memory as though it's happening now, that's worth noting gently — it may point to unprocessed material rather than simply vivid recall.

2. Know your scope.

EMDR, Brainspotting, CPT, and Prolonged Exposure are structured clinical protocols that require trained providers — this material is for understanding and referral, not for administering these therapies yourself.

3. You can still help without a protocol.

Simply helping someone place a memory in time — “when did this happen,” “what came before, what came after” — supports the same contextualizing work these therapies do, within an ordinary caring conversation.

Regulation & Anchors

- Self-Regulation
- Co-Regulation
- Reorientation — new world

The Brain and Grief

- Brain encodes bonds with another (person, animal, etc.).
- Brain anticipates seeing that person at specific times and places.
- Attachment bonds create a reward system in the brain when together — and the brain anticipates seeing them again when apart.
- When separated, stress hormones are released.
- Focus on trying to reunite so dopamine and oxytocin will be released.

We Are Built to Bond

The goal is not detachment and “moving on”! Before we can understand grief, we have to understand what the brain does when it forms a bond with another person in the first place.

How the Brain Encodes a Bond

John Bowlby's attachment theory describes an evolved system: we are biologically wired to form close bonds — with a person, and sometimes an animal — that function as a “secure base” for exploring the world.

The brain doesn't just remember that a bond exists — it encodes specifics: this particular person, and the times and places we expect to see them (a chair at dinner, a voice at 5pm, a face at the door).

Bowlby called this an “internal working model” — a mental map of who is available, how reliably, and what to expect from them — built from repeated experience, not conscious decision.

Oxytocin, Dopamine & Proximity

Attachment is underwritten by the brain's own reward system — the same dopamine-driven circuitry (the mesocorticolimbic pathway) involved in any deeply motivating reward.

Oxytocin and dopamine work as a team: oxytocin supports social recognition and safety, while dopamine drives motivation and approach. Together they make being close to our person feel good — and being apart feel motivating to fix.

In plain terms: when we're with someone we love, neurons fire and we are rewarded. The brain learns where that person is, and comes to anticipate seeing them again.

What Happens When We're Apart

The same system that rewards closeness has a built-in alarm for separation — one designed to motivate reunion, not to last forever.

The Alarm of Absence

Neuroscientist Jaak Panksepp identified a distinct brain circuit — the PANIC/GRIEF system — dedicated specifically to separation distress.

When separated from an attachment figure, oxytocin and the brain's own opioids (which normally soothe and reward) drop, while stress signaling (CRF) rises — producing real physiological distress, not just a feeling.

This system evolved for a purpose: to make separation feel urgent enough that infants and caregivers, or bonded partners, are motivated to find their way back to each other.

It is the same basic circuitry across mammals — which is part of why grief can feel so overwhelming and involuntary: it is an ancient, biologically wired alarm, not a choice or a character flaw.

Searching to Reunite

Separation distress doesn't just produce pain — it activates the brain's SEEKING system, the same dopaminergic drive behind motivation and “wanting.” The brain doesn't just hurt when apart; it goes looking.

This is why grief and yearning are restless, not passive — scanning a crowd for a familiar face, reaching for the phone, expecting footsteps at the door.

Reunion is the reward this whole system is built for: closeness restores oxytocin and opioid activity, dopamine reinforces the successful search, and the alarm quiets — at least until the next separation.

What the Animal Research Shows

Some of the clearest evidence for the biology of a broken bond comes from a small, monogamous rodent.

A Living Model of Broken Bonds (Prairie Voles)

Prairie voles are one of the few mammals that form long-term, monogamous pair bonds — making them a close model for studying human attachment and loss in the lab.

When a bonded pair is separated, voles show measurable stress responses that echo human grief — and, when a partner dies or is permanently removed, lasting changes in behavior.

Researchers have traced this to the nucleus accumbens (the same reward hub implicated in human yearning): prolonged separation erodes the gene-expression signature built up during the bond, alongside changes in oxytocin receptor activity.

In other words: the bond isn't just a feeling. It is a measurable biological structure — and losing it produces a measurable biological injury.

Grief Is Attachment With Nowhere to Go

The neurobiology of grief and the neurobiology of attachment are the same system, viewed at two different moments — one bonding, one broken.

When a person dies, the brain's internal working model doesn't simply delete them. There is a hole in the concept — the expectation of that person at that time, in that place, is still encoded and still firing.

So the brain keeps searching. This is what researcher Mary-Frances O'Connor calls the “gone-but-also-everlasting” model: the brain's nucleus accumbens still lights up with yearning, even as the person consciously knows the loved one is gone.

This is why grief is not primarily sadness about a fact — it is yearning and searching, the brain's oldest attachment desire for connection.

A System Built for Reunion, Facing a Loss With No Return

Every part of the separation-distress system assumes reunion is possible — and rewards the search the moment it succeeds. It has no “off switch” for a separation that will never resolve.

In ordinary separation, there is always a next time: a specific hour, a returning car, a phone call. In death, the brain is left trying to understand a separation with no specific time frame for reunion at all.

That open-endedness — not sadness alone — is what makes grief so disorienting. The alarm has nowhere to resolve to, so it can cycle for a long time, easing only gradually as the brain relearns the world without the expectation of return.

Faith and the Hope of Reunion

Neuroscience can describe the ache with precision. It cannot resolve it. Faith speaks directly into the one thing biology cannot supply: an actual promise of reunion.

Faith Gives the Brain What Grief Cannot: A Time and Place

The searching system was built around specific, known reunions — a particular time, a particular place. Death removes both. Christian hope answers this exact gap: not a vague comfort, but a promised, specific reunion.

Paul tells the Thessalonians not to “grieve like the rest of mankind, who have no hope” — not because grief is wrong, but because Christian grief is grief with a horizon: “since we believe that Jesus died and rose again, even so, through Jesus, God will bring with him those who have fallen asleep” (1 Thessalonians 4:13–14).

This doesn't erase the ache of “no specific time frame” in the present moment — but it gives the searching brain something the separation-distress system has never had before: a destination that is certain, even while its timing is not fully known.

Grief Process

- Over time, yearning declines and acceptance increases — but it does not do that in a linear fashion.
- Certain windows — death anniversary, holidays, birthdays, or other special events — can see a resurgence of grief as the brain searches for what is missing in the season or experience.
- Resurgence of the grief experience does not mean there is no progress.

The Grieving Body — And What Helps

Grief in the Body

- Grief triggers a profound physical stress response.
- Body may shift into “fight or flight” and flood with stress hormones.
- Body can be more impacted if there was a strong physical presence of the loved one prior to the loss.
- The body has to learn how to regulate and survive without that which has been lost.

Ways Grief Impacts You Physically

- Sleep
- Appetite / digestive issues
- Energy levels — fatigue
- Concentration — brain fog, “grief brain”
- Short-term memory issues
- Heart
- Headaches / migraines
- Breathing
- Immune system
- Pain

The Grieving Heart

A Stress-Stunned Heart, Not a Blocked One (Takotsubo)

Named for the Japanese octopus trap (takotsubo) its ballooned shape resembles — first described in 1990.

A surge of stress hormones (catecholamines) temporarily stuns the heart muscle, causing the left ventricle's tip to balloon outward while the base contracts hard — the reverse of a normal heartbeat.

Unlike a heart attack, the coronary arteries remain open and clear. This is the single clearest way to tell the two conditions apart — visible on a coronary angiogram.

It is usually reversible, with heart function typically recovering over days to weeks as the hormone surge subsides.

Who It Affects & How Often

- Overwhelmingly affects postmenopausal women — studies report women make up roughly 82–100% of cases, typically between ages 62 and 75.
- Estimated to account for about 1–2% of cases initially suspected to be acute coronary syndrome, though true incidence is likely underestimated.
- In the International Takotsubo Registry, an emotional trigger — grief, fear, anger, a frightening surprise — was identified in about 27.7% of patients; the remainder followed physical stressors like surgery or acute illness.

Not as Benign as Once Thought

Takotsubo has long been described as “usually reversible with a good prognosis.” A 2025 analysis of nearly 200,000 U.S. hospitalizations (2016–2020) tells a more sobering story.

In-hospital death occurred in 6.5% of cases, essentially unchanged across the five years studied — and men, though far less commonly affected, died at more than double the rate of women (11.2% vs. 5.5%).

Major complications were common: congestive heart failure (36%), atrial fibrillation (21%), cardiogenic shock (7%), stroke (5%), and cardiac arrest (3%).

Takeaway for helpers: “it’s just a broken heart, not a real heart attack” is not a safe reassurance to offer — this condition still requires emergency evaluation and carries real risk.

The Grieving Brain: How Loss Changes Memory, Attachment, and the Body

Grief is the brain and body adapting to the absence of someone still deeply encoded as important. — Core idea to remember

Grief Is a Learning Problem for the Brain

The mind can know someone is gone while attachment and reward systems still react as if reunion is possible. Current neurobiology reviews describe grief as involving emotion regulation, reward, cognitive control, endocrine, autonomic, and immune processes [1–3].

Attachment

The lost person remains highly salient in memory and motivation.

Reality Updating

The brain must revise expectations built through relationship and routine.

Body Response

Stress physiology can shift sleep, arousal, inflammation, and energy.

Why Yearning Feels So Powerful

PGD is partly distinguished by reward and appetitive processes. Regions such as the nucleus accumbens, striatum, orbitofrontal cortex, and basal ganglia may keep assigning motivational value to the deceased [1].

Plain-Language Translation

The brain may continue searching for the person it can no longer find.

Clinical Caution

The evidence base is still young, with small samples and methodological variability [1].

Reminders, Memory, and Identity

Threat and Salience

Amygdala, insula, and anterior cingulate systems help explain why reminders can arrive as emotional waves [1,2].

Memory

Hippocampal and amygdala findings connect grief with autobiographical memory and emotional learning [2].

Self and Future

Default-mode and cognitive-control networks help explain shifts in identity, attention, and future planning [1,2].

When Grief Gets Stuck

PGD involves persistent yearning or preoccupation plus distress and impairment beyond expected cultural, social, or religious norms [7]. It is not weakness or grieving wrong.

Symptoms

Disbelief, avoidance, identity disruption, emotional pain, numbness, loneliness, meaninglessness, or difficulty reintegrating [7].

Heterogeneity

Recent work found hundreds of PGD symptom profiles, showing PGD is not uniform [6].

Daily Life

Symptoms fluctuate by person and context; emotional numbness may influence later symptoms [4,5].

What Helps the Brain Update

Loss-Oriented Work

Paced reminders, death-story/narrative work, and accepting the reality of the loss.

Restoration-Oriented Work

Rebuilding roles, routines, connection, goals, and a livable future.

Body Support

Sleep care, movement, social contact, and treatment for co-occurring depression or anxiety.

Medication caveat: medications may help co-occurring symptoms, but current reviews caution against presenting grief as if it has one simple grief-specific drug target [8].

Grief Assessment Tools

Informal Assessment

May initially start with a life-impact timeline:

- Have you experienced the death of someone close to you?
- How long ago? (less than 6 months, 6–12 months, more than a year)
- Relationship, connection, and attachment to the deceased.
- Nature of the loss or death — sudden vs. long-term. How did they die?

List of Manner of Death

- Terminal illness
- COVID-19
- Accident
- Suicide
- Homicide
- Drug overdose
- Other

A Reference Guide for Helpers

Nine established instruments, what each measures, and where to find them.

Why Use a Formal Assessment

A structured tool doesn't replace a helper's judgment — it gives language, a baseline, and a way to notice change over time.

What an Assessment Is For

1. Screening

A brief tool flags when grief may need closer attention — a quick, low-burden first pass, not a diagnosis.

2. Diagnosis

A validated scale, applied against clinical criteria (such as the DSM-5-TR), supports identifying Prolonged Grief Disorder specifically.

3. Treatment Planning & Tracking

Repeating a measure over time shows whether a person is moving, stuck, or worsening — informing what kind of support to offer next.

General & Complicated Grief Measures

Six widely used, peer-reviewed instruments for measuring grief intensity and identifying complicated or prolonged grief.

Complicated & Prolonged Grief Scales

1. Inventory of Complicated Grief (ICG)

19-item self-report (Prigerson et al., 1995), each item rated 0–4. Total scores above 25 (of 76) flag clinically significant, impairing grief.

Link: <https://psychology-tools.com/test/inventory-complicated-grief>

2. Prolonged Grief Disorder-13-Revised (PG-13-R)

13-item scale (Prigerson, Xu & Maciejewski, 2021) built for the DSM-5-TR criteria; a score above 30 plus the 12-month and impairment criteria supports a diagnosis.

Link: <https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20823>

3. Texas Revised Inventory of Grief (TRIG)

Two-part scale (Faschingbauer et al.) covering past grief behaviors and present feelings — widely used to track grief intensity over time.

Link: <https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/texas-grief>

Screening & Multidimensional Scales

4. Hogan Grief Reaction Checklist (HGRC)

Empirically derived measure (Hogan & Schmidt, 2001) spanning six factors — Despair, Panic Behavior, Blame & Anger, Detachment, Disorganization, Personal Growth — the only major tool that also captures growth.

Link: <https://www.tandfonline.com/doi/abs/10.1080/07481180125831>

5. Brief Grief Questionnaire (BGQ)

5-item screener (Shear & Essock) developed after 9/11; a score of 4 or higher (of 10) flags grief that warrants closer evaluation — ideal for a quick first pass.

Link: <https://prolongedgrief.columbia.edu/brief-grief-questionnaire/>

6. Core Bereavement Items (CBI)

17-item scale (Burnett et al., 1997) measuring “core” grief phenomena — Images & Thoughts, Acute Separation, General Grief — built for normal, not just pathological, grief.

Link: https://www.cambridge.org/core/services/aop-cambridge-core/content/view/233D304731941CF8C85A19004992473B/S0033291796004151a.pdf/measuring_core_bereavement_phenomena.pdf

Specialized & Population-Specific Tools

Three instruments built for particular kinds of loss: anticipatory caregiver grief, perinatal loss, and the ongoing relationship to the deceased.

Marwit-Meuser Caregiver Grief Inventory (MM-CGI)

Measures pre-death (anticipatory) grief in family caregivers of people with dementia. The 18-item short form spans Personal Sacrifice & Burden, Heartfelt Sadness & Longing, and Worry & Isolation.

Link: <https://pubmed.ncbi.nlm.nih.gov/15816111/>

Perinatal Grief Scale (PGS)

33-item short-form scale (Toedter, Lasker & Alhadeff, building on Potvin et al., 1989) for miscarriage, stillbirth, and neonatal death, with Active Grief, Difficulty Coping, and Despair subscales.

Link: <https://judithlasker.com/wp-content/uploads/2024/01/pgs-scale-and-scoring.pdf>

Two-Track Bereavement Questionnaire (TTBQ)

Rubin's relational model measure; the 31-item short form (TTBQ-CG31) assesses both biopsychosocial functioning and the ongoing relationship to the deceased.

Link: <https://sites.google.com/hevra.haifa.ac.il/prof-simon-shimshon-rubin/publications/two-track-bereavement-questionnaire>

Nine Tools at a Glance

Tool	Focus / Population	Length	Best For
ICG	Complicated grief severity	19 items	Measuring symptom severity in adults
PG-13-R	DSM-5-TR Prolonged Grief Disorder	13 items	Diagnostic screening for PGD
TRIG	Grief intensity, past & present	13–21 items	Tracking grief over time
HGRC	Multidimensional grief reactions	61 items	Capturing distress and personal growth
BGQ	General screening	5 items	A fast first-pass check-in
CBI	Normal grief phenomena	17 items	Non-pathologizing grief assessment
MM-CGI	Caregivers of people with dementia	18 items (short form)	Anticipatory / pre-death grief

Tool	Focus / Population	Length	Best For
PGS	Miscarriage, stillbirth, neonatal death	33 items (short form)	Perinatal and pregnancy loss
TTBQ	Ongoing relationship to the deceased	31 items (short form)	Relational, not just symptom-based, grief

Using These Tools Well

1. Pair the score with clinical judgment.

No tool diagnoses on its own — a high score is an invitation to a closer conversation, not a verdict.

2. Consider culture and context.

Grief expression varies widely; most of these tools were validated on Western samples and should be applied with that in mind.

3. Use it as a bridge to conversation, not a label.

The best use of a screening tool is often simply opening a door: “Would it help to talk about how heavy this has felt?”

Grief Pattern Inventory & Grieving Styles

Grief Pattern Inventory

Developed by Kenneth J. Doka and Terry L. Martin.

30-item questionnaire to measure individual styles of grieving.

First described in “Men Don't Cry, Women Do: Transcending Gender Stereotypes of Grief”, written in 2000.

Core Grief Patterns

Intuitive Griever — Heart Grievers — Feelers

Involves deep emotional expression.

Instrumental Griever — Head Grievers — Thinkers

Focuses on physical and cognitive actions.

Blended Patterns

A mix of both.

Dissonant Grievers

Internal conflict when a person's natural grieving expression clashes with outward social expectations.

Grieving Styles — Instrumental

- “Head” grievers
- Focus on cognition over feelings
- Focus on problem solving and planned activities
- Less comfortable with strong feelings
- May explain circumstances of loss rather than feelings

Grieving Styles — Intuitive

- “Heart” grievers
- Focus on feelings over cognition
- Longer cognitive impairment with inability to concentrate
- Feelings are intensely experienced (crying / lamenting)
- Connect with feelings of others

Blended / Dissonant Grief

- Blended grievers may experience both patterns — or different patterns with different losses or roles.
- Dissonant patterns occur when internal reality and need cannot be expressed externally.
- Often cultural or gender-role expectations don't match with the person's natural grief pattern.

Grief Support for Grieving Styles

- Instrumental grievers
- Intuitive grievers
- Blended grievers
- Helping the griever with dissonance

What Helps

What Helps?

- Psychoeducation
- Social support
- Processing tools based on grieving style, type of loss, and timeline since the loss
- Development of continuing bonds
- Long-term growth — meaning making

Psychoeducation

- Education about how grief impacts brain and body
- What is normal? What is not normal?
- Good self-care
- Avoiding unhealthy coping

Healthy Coping

Assess healthy coping and assist clients in cultivating healthy habits:

- Mental health
- Physical health
- Spiritual health

Healthy Coping — Mental Health

- Talk about the loss and who or what was lost.
- Have healthy relationships (can be a small circle but needs depth).
- Ways to remember and process that fit with personal grieving style and the loss.

Healthy Coping — Physical Health

- Regular doctor and dental appointments
- Physical exercise
- Sleep
- Service — serving others, even a pet
- Nutrition

Healthy Coping — Spiritual Health

- A crisis of faith can be normal.
- Anger at God is normal.
- They need safety to explore doubt and anger and process through it.
- They need community — even if they can't go back to church right away, or the same church.
- Theology of suffering — their faith may need to be rebuilt.

Unhealthy Coping

Biggest unhealthy coping behaviors to screen for:

- Self-medication — alcohol most common, but any self-medication: food, drugs, alcohol, sex, gambling, etc.
- Isolation and withdrawal — from work, friends, faith community.
- Unhealthy relationships / self-harm.
- Loss of meaning and purpose.

Companion vs. Counsel

Companion vs. Counsel

Grief support is best as “companioning” — coming alongside someone for the journey as another who has walked a similar path or has been companion to others on a similar journey (similar, not same).

- Each loss is unique, but there are commonalities based on neurobiology.
- People have different personalities and grieving styles.

Life Givers and Suckers: People (Exercise)

Map the people in your life: who gives you life, and who drains it? Place names around “YOU” at the center.

Work for the Griever

- You must know what you need.
- You must learn how to ask for what you need.
- Educate your healthy support.
- Set boundaries with those who are not helpful or who are trying to lean too heavily on you for support.

Tools

- Talking about the loss
- Timeline
- Memorials and rituals
- Remembering and reliving the process of building the attachment

Does not have to be linear — but revisiting the significant points in forming the attachment bonds.

Experiential Grief Exercises

- Grief / loss timeline
- Writing to the person you lost — song, poem, letter, story
- Empty chair

Funerals / Memorials

- Important to honor religious / cultural traditions.
- Some people may need more than a one-time event.
- Creative ideas on how to honor the loved one and help the brain recognize relocation.

Continuing Bonds

Continuing Bonds

This concept helps the brain and the body “relocate” the missing piece.

Understand they are not in the present physical space and time with you, but this allows you to keep their memory and spirit connected in a way that still allows the best elements of love to stay present in our lives.

Holding On and Letting Go

Repositioning and reframing vs. detachment.

Continuing Bonds — Practical Ideas

Help the brain relocate the person from the present — you won't be with them in the present. How to keep the “presence” or memory with you today, in the present:

- Carry a remembrance item
- Create something in the loved one's memory (art, story, music)
- Giveaway ritual
- Cook a meal in their honor
- Create a memorial space to visit

Loss

“Nothing can make up for the absence of someone whom we love...it is nonsense to say that God fills the gap; God doesn't fill it, but on the contrary, God keeps it empty and so helps us to keep alive our former communion with each other, even at the cost of pain...The dearer and richer our memories, the more difficult the separation. But gratitude changes the pangs of memory into a tranquil joy. The beauties of the past are borne, not as a thorn in the flesh, but as a precious gift in themselves.” — Dietrich Bonhoeffer

Faith

- Explore the individual's faith and their beliefs about death and the afterlife.
- For Christians, this is the greatest source of healing and comfort.
- Be careful not to thwart coping.
- Be careful about correcting theology.
- Remember to ask — “Is this helping them to cope, or impairing / blocking their process?”

Continuing Bonds — Rando's Two Conditions

Rando (1993) describes two conditions for a healthy continuing bond with the deceased:

1. Recognize that the person is dead, and the implications.
2. The bond must not interfere with moving forward into a new life.

Long-Term Recovery

Long-Term Recovery

- No “normal” — large variation in healthy recovery.
- No one timeline, but a general guideline.
- General loss — most challenging in the first 1–2 years.
- Certain types of loss — homicide, suicide, missing loved one — may take significantly longer.

Bereavement Science

- Resilient people are less likely to use avoidance and distraction as coping.
- Understand that waves of grief will become episodic.
- Find comfort in talking about or thinking about the deceased.
- Common to experience a full range of emotions following loss (both happiness and sadness).
- Common to have continuing bonds, but the relationship must change.

When It Doesn't Get Better

Signs of PGD

Signs that someone is stuck or not moving forward:

- Over time, dysfunction in life will be seen.
- Manifests in the mind — mental health issues.
- Manifests in the body — physical illness, chronic pain, or health conditions.
- Manifests socially / spiritually — “chronic anger, annoyance, or a combination of anger and depression (e.g. irritability, belligerence, intolerance).”

Prolonged Grief Disorder

An individual with prolonged grief disorder (PGD) may experience intense longing for the person who has died and/or feelings of being preoccupied by thoughts of the death of that person.

Only a small percentage of people will develop PGD.

Prolonged Grief Disorder — Symptoms (APA, 2022)

- Identity disruption (such as feeling as though part of oneself has died).
- Marked sense of disbelief about the death.
- Avoidance of reminders that the person is dead.
- Intense emotional pain (such as anger, bitterness, sorrow) related to the death.
- Difficulty with reintegration (such as problems engaging with friends, pursuing interests, planning for the future).
- Emotional numbness (absence or marked reduction of emotional experience).
- Feeling that life is meaningless without the deceased person.
- Intense loneliness (feeling alone or detached from others).

Prolonged Grief Symptoms — Prevalence

An estimated 4%–15% of bereaved adults will experience the persistent symptoms of prolonged grief disorder (Prigerson et al., 2021; Doering et al., 2022).

When It Doesn't Get Better

Start with an attitude of inquiry and exploration.

- Grief process gets “derailed” by pre- or post-death factors.
- Poor coping and avoidance actions.
- Avoidance of painful feelings associated with the grief process.
- Relational complications or deficits.

Factors That “Derail” the Grief Process

- Problems present prior to the loss.
- Mental, physical, or spiritual health issues present (but may not be apparent) prior to the loss.
- Issues surrounding the loss that create challenges or trauma (homicide, suicide, traumatic or untimely death).
- Behaviors and actions that the bereaved use to “avoid” grief.
- Environmental factors and lack of support.