Good Grief, Complicated Grief & Traumatic Grief

A 12-Week Program for Those Supporting a Grieving Person

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This manual does not replace professional treatment.
It supplements it.

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Each week includes: Session Objectives, Supporter Checklist, Session Script, and a Printable Worksheet. Appendices include: Regulation Toolkit, Digital Toolkit Guide, and Guided Imagery Scripts.

Introduction

Grief is not a disorder. It is a debt owed for the relationship. But when someone you care about is grieving \u2014 whether they lost a parent last month, a child last year, or a partner to suicide \u2014 you are watching them suffer and you don't know what to do. You say the wrong thing. You avoid them because you're afraid of saying the wrong thing. You try to fix it. You get frustrated when they're "still not over it." You feel helpless.

This manual exists because grief illiteracy is the norm. Our culture has no framework for supporting someone through loss. We get three days of bereavement leave and a casserole. Then we're expected to "be there" for someone without any training in what "being there" actually requires.

What This Manual Covers

This is not a grief recovery program for the person who is grieving. This is a supporter's education \u2014 a 12-week structured curriculum that teaches you:

• What grief actually is (neurobiologically, psychologically, relationally)
• The difference between normal grief, complicated/prolonged grief, and traumatic grief
• What helps, what hurts, and what is not your job
• How to hold space without fixing, rescuing, or collapsing
• When to encourage professional help and how to recognize danger signs
• How to sustain yourself through someone else's grief without burning out

Three Types of Grief

Good Grief (normal bereavement) is painful but adaptive. The griever moves through waves of intense pain interspersed with periods of functioning. Over months, the waves become less frequent and less consuming. Most people (90\u201397%) navigate grief without clinical intervention. Your job is to not interfere with this natural process while providing consistent presence.

Complicated Grief (Prolonged Grief Disorder \u2014 now a formal diagnosis in DSM-5-TR and ICD-11) occurs when grief remains intense, preoccupying, and functionally impairing beyond 12 months. The griever cannot integrate the reality of the loss. They are stuck \u2014 not because they loved more, but because something in the grief process has become blocked. Approximately 3\u201310% of bereaved people develop PGD.

Traumatic Grief occurs when the death itself was traumatic \u2014 sudden, violent, witnessed, or horrific in its circumstances (homicide, suicide, accident, disaster). The trauma symptoms (intrusion, avoidance, hyperarousal) interfere with the grief process. The person cannot mourn because they cannot think about the deceased without being flooded by traumatic imagery. This requires addressing trauma before or alongside grief.

The Dual Process Model

This manual uses Stroebe and Schut's Dual Process Model (1999) as its organizing

framework. Healthy grief involves oscillation between two orientations:

• Loss-orientation: Grief work, yearning, crying, remembering, looking at photos
• Restoration-orientation: Attending to life changes, new roles, new identity, practical tasks, distraction

Both are necessary. Neither is pathological. Your job as supporter is to allow oscillation \u2014 not to force either orientation. Don't say "you need to move on" (forcing restoration). Don't say "you need to feel your feelings more" (forcing loss-orientation). Let them move between the two at their own pace.

A Critical Clarification

This is a 12-week program for your education as a supporter. The person you're supporting will not be "done grieving" in 12 weeks. Grief has no timeline. Worden's Task 4 \u2014 finding an enduring connection with the deceased while embarking on a new life \u2014 is lifelong work. You are learning skills that you will use for months or years. The 12-week structure gives you a framework; it does not give grief a deadline.

Clinical Foundation: This manual integrates Worden's Four Tasks of Mourning (2018), the Dual Process Model (Stroebe & Schut, 1999), Shear's Prolonged Grief Disorder Therapy protocol, Continuing Bonds theory (Klass, Silverman & Nickman, 1996), and polyvagal-informed nervous system education (Porges, Dana). All translated into plain language for non-clinicians.

WEEK 1
What Grief Actually Is

Understanding grief as a neurobiological process, not a problem to solve.

Session Objectives

- Understand grief as adaptive, not pathological
- Learn the Dual Process Model (oscillation between loss and restoration)
- Identify your own assumptions about grief that may be getting in the way
- Establish your role: witness, not fixer

Supporter Checklist

[ ] Check-in: How are YOU doing with this person's grief?
[ ] Introduce the concept: Grief is not a problem to solve
[ ] Teach the Dual Process Model (loss-orientation vs. restoration-orientation)
[ ] Identify one assumption you hold about grief that might not be true
[ ] Complete Worksheet: My Grief Assumptions Inventory

Session Script

You (to yourself): "Before I can support someone through grief, I need to understand what grief actually is \u2014 and what it isn't. Most of what our culture teaches about grief is wrong."

Key Concept: Grief Is Not Linear

*"You've probably heard of the 'five stages of grief' \u2014 denial, anger, bargaining, depression, acceptance. K\u00fcbler-Ross wrote those in 1969 in *On Death and Dying* about people facing their own terminal diagnosis, not about bereaved people. She later clarified in *On Grief and Grieving* (2005, co-authored with David Kessler) that the stages were never meant to be linear, never meant to be prescriptive, and never meant to describe bereavement. They were observations, not instructions. And yet they've become the dominant cultural script \u2014 a checklist people use to judge whether someone is 'doing grief right.'"*

"K\u00fcbler-Ross herself wrote: 'They were never meant to help tuck messy emotions into neat packages.' The damage done by misapplying her work is enormous. Grievers get told they're 'stuck in anger' or 'haven't reached acceptance yet' \u2014 as if grief has a finish line you can cross if you just do it correctly."

*"Here's what actually happens: Grief comes in waves. Joan Didion captured this perfectly in *The Year of Magical Thinking* \u2014 she described the 'ordinary instant' when her husband dropped dead at the dinner table, and then the months of magical thinking that followed. She kept his shoes because he would need them when he came back. She couldn't read his obituary. She knew intellectually he was*

dead and simultaneously could not integrate that knowledge into her body. That's not a stage. That's not denial. That's the gap between cognitive knowing and embodied knowing \u2014 and it's neurobiological, not pathological."

"Some days the person you're supporting will seem fine \u2014 laughing, working, making dinner. Other days they'll be flattened. This is not 'regression.' This is not 'not doing their grief work.' This is the Dual Process Model in action."

Key Concept: The Dual Process Model (Stroebe & Schut, 1999)

"Margaret Stroebe and Henk Schut observed that healthy grievers oscillate between two modes:"

"Loss-orientation \u2014 this is the grief work. Crying, yearning, looking at photos, talking about the person, replaying memories, feeling the absence. This is where the pain lives."

"Restoration-orientation \u2014 this is life-rebuilding. Paying bills, learning new skills the deceased used to handle, forming new routines, engaging with the world, sometimes even feeling relief or pleasure. This is where adaptation lives."

"Both are necessary. The griever needs to move between them. Your job is to not get in the way of this oscillation. Don't push them toward either pole."

Common Mistakes Supporters Make:

"If you say 'You need to let yourself cry more' \u2014 you're forcing loss-orientation on someone who might need a break from it."

"If you say 'It's been six months, maybe it's time to start dating again' \u2014 you're forcing restoration-orientation on someone who isn't ready."

"If you stop mentioning the deceased's name because you're afraid of 'reminding them' \u2014 you're not protecting them. They haven't forgotten. You're just telling them their grief makes you uncomfortable."

Key Concept: Grief as Evidence of Love

"Jim Carrey described grief as an 'unraveling' ~ a profound void where something once lived but is now gone, creating a hollow ache. He called it sacred. Not an emotion to manage, but a transformative experience that proves deep love existed. If you're watching someone grieve and it looks like they're falling apart ~ they are. That's not failure. That's the architecture of attachment doing exactly what it was built to do when the person it was built around disappears."

"Carrey also said something that matters for you as a supporter: instead of 'moving on,' one learns to 'move with' grief ~ integrating the loss, carrying both love and pain forward. That reframe changes everything about how you show up. You're not helping them get over it. You're helping them learn to carry it."

"A.A. Milne wrote in Winnie the Pooh: 'How lucky I am to have something that makes saying goodbye so hard.' That's not sentimentality. That's the actual clinical truth ~ the depth of grief is directly proportional to the depth of attachment. Grief is not a malfunction. It's the receipt for love."

Your Role: Witness, Not Fixer

"Your job is not to make the grief go away. You cannot do that. Your job is to be a consistent, non-anxious presence who can tolerate their pain without trying to fix it, rush it, or make it smaller than it is."

"That's harder than it sounds. Most of us are deeply uncomfortable with other people's pain. We want to say something that helps. But in grief, the most helpful thing is often silence, presence, and the willingness to sit in discomfort without fleeing."

> *What the Research Shows*

> *Stroebe and Schut's Dual Process Model (1999, updated 2010) has become the dominant empirical framework for understanding adaptive grief. Their research demonstrates that oscillation between loss-oriented and restoration-oriented coping is characteristic of healthy bereavement, while getting stuck in either orientation is associated with complications. A 2021 meta-analysis in Death Studies confirmed that interventions supporting natural oscillation produce better outcomes than those forcing either grief confrontation or distraction.*

> *Key Sources for This Week:*
> *- K\u00fcbler-Ross, E. (1969). On Death and Dying. Scribner.*
> *- K\u00fcbler-Ross, E. & Kessler, D. (2005). On Grief and Grieving. Scribner.*
> *- Didion, J. (2005). The Year of Magical Thinking. Knopf.*
> *- Stroebe, M. & Schut, H. (1999). The Dual Process Model of Coping with Bereavement. Death Studies, 23(3), 197\u2013224.*

Nervous System Regulation Exercise: Grounding Through the Senses

"Grief can pull you out of the present moment \u2014 either into the past (replaying the loss) or into the future (catastrophizing about life without them). Here's a simple grounding exercise you can use when you notice yourself or the person you're supporting getting overwhelmed."

"It's called 5-4-3-2-1. Name 5 things you can see. 4 things you can touch. 3 things you can hear. 2 things you can smell. 1 thing you can taste. It brings the nervous system back to the present moment."

> *Why this works: Grief activates the limbic system and can trigger both sympathetic (fight/flight) and dorsal vagal (freeze/collapse) responses. Sensory grounding engages the prefrontal cortex and orients the nervous system to present-moment safety, widening the Window of Tolerance.*

"You can do this silently for yourself when you're feeling overwhelmed by their grief. You can also guide them through it if they're flooding."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 2
The Nervous System in Grief

How loss dysregulates the body and what that looks like from the outside.

Session Objectives

- Understand the Window of Tolerance in the context of grief
- Recognize hyperarousal and hypoarousal in a grieving person
- Learn why grief is exhausting (it's neurobiological, not weakness)
- Identify your own nervous system responses to their grief

Supporter Checklist

[ ] Check-in: What did you notice about your grief assumptions this week?
[ ] Teach the Window of Tolerance applied to grief
[ ] Explain why grief is physically exhausting
[ ] Identify what zone the person you're supporting seems to be in most often
[ ] Complete Worksheet: Tracking Their Zones (and Yours)

Session Script

"Last week we talked about what grief is psychologically. This week we're going below the neck. Grief is not just an emotion \u2014 it's a full-body neurobiological event. Understanding this will change how you interpret what you're seeing."

Key Concept: The Window of Tolerance in Grief

"The Window of Tolerance \u2014 developed by Dan Siegel and expanded by Pat Ogden \u2014 describes the zone of arousal in which a person can function, think clearly, feel emotions without being overwhelmed, and connect with others."

"Inside the window (the green zone): The griever can talk about the deceased, feel sadness, and still function. They might cry and then make dinner. They might feel a wave of pain and then call a friend. This is healthy oscillation."

"Above the window (the red zone \u2014 hyperarousal): The griever is flooded. Panic, rage, uncontrollable sobbing, racing thoughts, inability to sleep, hypervigilance. In traumatic grief, this often includes intrusive images of how the person died."

"Below the window (the grey zone \u2014 hypoarousal): The griever is shut down. Numbness, dissociation, flat affect, inability to cry even when they want to, sleeping 14 hours a day, the 'thousand-yard stare.' This is not indifference. This is the nervous system's circuit breaker."

"Here's what matters for you as a supporter: You cannot push someone back into their window. You can only create conditions that make it safe enough for their nervous system to return on its own."

Why Grief Is Physically Exhausting

"Grief activates the hypothalamic-pituitary-adrenal (HPA) axis \u2014 the same stress response system that fires during threat. Cortisol floods the body. The immune system is suppressed. Sleep architecture is disrupted. Appetite changes. The heart literally aches \u2014 takotsubo cardiomyopathy ('broken heart syndrome') is a real medical condition triggered by grief."

"When the person you're supporting says 'I'm so tired' \u2014 they're not being dramatic. Their body is running a stress response 24 hours a day. Grief is as physically demanding as recovering from surgery. They need rest, not productivity."

What You Might See (And What It Means)

"If they're pacing, can't sit still, talking rapidly about the death, startling easily \u2014 they're above the window. Don't tell them to calm down. Sit with them. Breathe slowly yourself. Your regulated nervous system can co-regulate theirs."

"If they're staring blankly, not responding to questions, moving in slow motion, saying 'I'm fine' in a flat voice \u2014 they're below the window. Don't try to 'snap them out of it.' Gentle sensory input: warm tea, a blanket, soft music. Orient them to the present without demanding engagement."

"If they're crying but can still talk to you, making eye contact, asking for what they need \u2014 they're inside the window. This is where grief processing happens. Don't interrupt it. Don't try to stop the tears. This is the work."

Your Nervous System Matters Too

"Here's what nobody tells supporters: their grief will dysregulate YOUR nervous system. Watching someone you love suffer activates your own threat response. You might notice yourself getting irritable, avoidant, or numb after spending time with them. That's not selfishness. That's co-regulation working in reverse."

"You need to track your own window. If you're consistently leaving interactions with them feeling depleted, anxious, or shut down \u2014 you need your own regulation practices. You cannot pour from an empty cup, and you cannot co-regulate from outside your own window."

> *What the Research Shows*

> *O'Connor (2019) demonstrated via fMRI that grief activates the nucleus accumbens (reward/craving center), explaining the intense yearning component. Grief also disrupts the default mode network, which is responsible for self-referential processing and future planning \u2014 explaining why grievers report feeling "lost" or unable to imagine the future. Shear et al. (2007) found that the nervous system dysregulation in complicated grief mirrors that seen in PTSD, with similar patterns of amygdala hyperactivation and prefrontal hypoactivation.*

Nervous System Regulation Exercise: Bilateral Stimulation (Butterfly Hug)

"This is a self-administered bilateral stimulation technique originally developed for EMDR but widely used for emotional regulation. Cross your arms over your chest, hands resting on opposite shoulders. Alternate tapping \u2014 left, right, left, right \u2014 at a pace that feels comfortable. Continue for 30\u201360 seconds."

> *Why this works: Bilateral stimulation activates both hemispheres of the brain and appears to facilitate emotional processing by engaging the same mechanisms used in REM sleep. It can help move the nervous system from hyperarousal back toward the window without requiring verbal processing.*

"You can teach this to the person you're supporting as a self-regulation tool. It's particularly useful when they're flooding and can't access words."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 3

Three Types of Grief

Distinguishing normal grief from complicated grief and traumatic grief.

Session Objectives

- Understand the clinical distinction between normal, complicated, and traumatic grief
- Learn the DSM-5-TR criteria for Prolonged Grief Disorder
- Recognize when grief has become 'stuck'
- Understand why traumatic grief requires different support

Supporter Checklist

[ ] Check-in: What zones did you notice this week (theirs and yours)?
[ ] Teach the three types of grief with clear distinctions
[ ] Introduce Worden's Four Tasks as a framework for normal grief
[ ] Explain what 'stuck' grief looks like
[ ] Complete Worksheet: Which Type of Grief Am I Seeing?

Session Script

"This week we're making distinctions that matter. Not all grief is the same, and the type of grief the person you're supporting is experiencing determines what kind of support they need."

Type 1: Good Grief (Normal Bereavement)

"Normal grief is painful, disorienting, and exhausting \u2014 but it's adaptive. The griever is doing the work of integrating a new reality. Worden described four tasks that characterize this process:"

"Task 1: Accepting the reality of the loss. This sounds obvious, but it takes time. The griever might intellectually know the person is dead but still reach for the phone to call them. Still set a place at the table. Still expect them to walk through the door. This is not denial \u2014 it's the gap between intellectual knowing and embodied knowing."

"Task 2: Processing the pain of grief. Not avoiding it, not wallowing in it \u2014 processing it. Feeling the waves when they come. Crying when tears arrive. Sitting with the emptiness. This is the loss-orientation side of the Dual Process Model."

"Task 3: Adjusting to a world without the deceased. This includes external adjustments (who pays the bills now? who drives the kids?), internal adjustments (who am I without this person?), and spiritual adjustments (what do I believe about life and death now?)."

"Task 4: Finding an enduring connection with the deceased while embarking on a new life. This is not 'letting go.' This is transforming the relationship from one of presence to one of memory, legacy, and continuing bonds. The deceased remains part of the griever's life \u2014 just differently."

"In normal grief, these tasks unfold over months to years. The griever moves through them non-linearly, revisiting earlier tasks as new aspects of the loss emerge. Your job is to support each task without rushing any of them."

Type 2: Complicated Grief (Prolonged Grief Disorder)

"Prolonged Grief Disorder became a formal diagnosis in 2022 \u2014 in both the DSM-5-TR and the ICD-11. This was controversial, because many people feared it would pathologize normal grief. The diagnostic criteria are deliberately conservative:"

"The death must have occurred at least 12 months ago for adults (6 months for children). The person must experience intense yearning or preoccupation with the deceased nearly every day. And they must have at least three of these symptoms: identity disruption, marked disbelief about the death, avoidance of reminders, intense emotional pain, difficulty reintegrating into life, emotional numbness, feeling life is meaningless, or intense loneliness."

"The key distinction: In normal grief, the pain gradually softens. In PGD, it doesn't. The griever is stuck in acute grief \u2014 as raw at 18 months as they were at 18 days. They cannot integrate the loss. They cannot imagine a future. They are frozen in the moment of absence."

*"Alan Wolfelt, in *Complicated Grief: How to Understand, Express, and Reconcile Your Especially Difficult Grief*, frames this not as pathology but as grief that has encountered obstacles \u2014 insecure attachment, lack of social support, prior unresolved losses, or a death that violated the natural order (a child dying before a parent). Wolfelt's 'companioning' model reminds us that even complicated grief deserves presence, not just diagnosis."*

"This is not about loving more. This is about the grief process becoming blocked \u2014 often by insecure attachment, prior unresolved losses, dependency on the deceased, or lack of social support."

When Grief Won't Move: The Significance Problem

"In thirty years of sitting with people who cannot let go, I've noticed something that doesn't show up in the PGD criteria or the bereavement textbooks. The person who is stuck \u2014 truly stuck, not just grieving on a timeline that makes other people uncomfortable \u2014 is almost never stuck because they loved too much. They're stuck because the deceased person's life needs to mean something, and they haven't figured out how to make that happen yet."

"This is not pathology. This is logic. If I stop grieving, the world moves on. If the world moves on, my person becomes a name on a headstone that strangers walk past. If my person becomes forgettable, then what was the point of their entire existence? So I hold the grief like a torch. I keep it burning because as long as I'm suffering, the relationship is still real. The pain is proof that they mattered."

"Sweet Honey in the Rock captured this exactly in 'Wanting Memories' (Ysaye Maria Barnwell, 1993):"

> *I am sitting here wanting memories to teach me*
> *To see the beauty in the world*
> *Through my own eyes*

*"That's the significance problem in three lines. The griever is sitting \u2014 not moving, not 'processing,' not checking off stages \u2014 because the beauty in the world was something they saw *through the other person's eyes*. Without that person, the beauty disappears. The grief isn't blocking their vision. The grief *is* their vision. It's the last channel through which the relationship still transmits."*

> *Since you've gone and left me*
> *There's been so little beauty*
> *But I know I saw it clearly through your eyes*

"And then the song does what good grief work does. It doesn't tell the person to let go. It doesn't offer five stages or a timeline. It sits in the wanting long enough for something to shift:"

> *I thought that you were gone*
> *But now I know you're with me*
> *You are the voice that whispers all I need to hear*

*"That's the turn. Not 'I've moved on.' Not 'I've accepted the loss.' But: *you are still here \u2014 in what you taught me, in what you left inside me, in the way I see the world now because you were in it.*"*

> *I know that I am you and you are me and we are one*

"The supporter's job here is not to talk someone out of their grief. It's to help them find another vehicle for significance. The question isn't 'How do I get them to let go?' The question is 'What would make them feel like their person's life still counts for something in the world?'"

"Sometimes that's a scholarship fund. Sometimes it's a story they tell at Thanksgiving. Sometimes it's a garden. Sometimes it's just someone saying the dead person's name out loud in a room full of people who've stopped saying it."

"You don't treat this with CBT. You don't reframe it. You help them build a container for the significance that isn't made of suffering."

\ud83c\udfa7 Listen: [Sweet Honey in the Rock \u2014 \"Wanting Memories\"](https://youtu.be/lHJe0mv_oYU?si=3vK07fSBlZzhs3NZ) (YouTube, 5 min). Play this before journaling.

Reflective Journaling Prompt

> *"Before we move on, take ten minutes with your journal. These questions are for you \u2014 the supporter \u2014 not the griever."*

1. What did the deceased person's life mean to the person you're supporting? Not what they did \u2014 what their existence meant.
2. If the griever is holding pain as proof of significance, what else might serve as that proof? What container could hold the meaning without requiring suffering?
3. Have you ever said the deceased person's name out loud recently \u2014 not in the context of the death, but in the context of their life? What story would you tell?
4. What did you hear in \"Wanting Memories\" that reminded you of the person you're supporting?

> *"There are no wrong answers here. This is not a worksheet to complete. It's a mirror."*

\u27a1\ufe0f Next: We move from understanding the types of grief to understanding your role. Week 4 covers the three supporter roles \u2014 witness, practical helper, and boundary-holder \u2014 and what grieving people actually find helpful (versus what we assume helps).

Type 3: Traumatic Grief

> *"Traumatic grief occurs when the death itself was traumatic. Homicide. Suicide. A car accident you witnessed. Finding the body. A death that was sudden, violent, or horrific in its circumstances."*

> *"Alan Wolfelt, in *Reframing PTSD as Traumatic Grief*, makes a powerful argument: What we call 'PTSD' after a death is often better understood as traumatic grief \u2014 grief that has been complicated by trauma, not a separate disorder that happens to co-occur with loss. This reframing matters because it keeps the grief at the center rather than treating it as secondary to the trauma diagnosis."*

> *"Here's the clinical problem: Trauma and grief pull in opposite directions. Grief requires approaching the loss \u2014 thinking about the person, feeling the pain, integrating the reality. Trauma requires avoiding the overwhelming material \u2014 the intrusive images, the horror, the helplessness."*

"So the person with traumatic grief is caught in a bind: They cannot grieve because every time they think about the person they loved, they are flooded with traumatic imagery of how that person died. The trauma blocks the grief. The grief amplifies the trauma."

"This is why traumatic grief almost always requires professional help. The trauma needs to be processed \u2014 usually through EMDR, CPT, or prolonged exposure \u2014 before the natural grief process can resume. Your job as supporter is to recognize this pattern and encourage treatment, not to try to be the therapist."

*"Jennifer Levin's *The Traumatic Loss Workbook* offers practical exercises for people navigating this territory \u2014 structured activities that help the griever approach the traumatic material in titrated doses rather than being overwhelmed by it. The Hospice Foundation of America's *Shattered* anthology collects clinical perspectives on exactly this intersection \u2014 how trauma shatters the normal grief process and what it takes to reassemble it. Both are worth recommending if the person you're supporting is dealing with traumatic grief."*

How to Tell Which Type You're Seeing

"Ask yourself these questions: Has it been more than a year and the pain is as raw as it was in the first month? That might be PGD. Was the death sudden, violent, or witnessed? That might be traumatic grief. Is the person oscillating between pain and functioning, with the pain gradually becoming less consuming? That's probably normal grief doing its work."

What the Research Shows

Prigerson et al. (2021) published the definitive review of Prolonged Grief Disorder in the New England Journal of Medicine, establishing that PGD affects 3\u201310% of bereaved individuals after natural deaths, with substantially higher rates after child loss, partner loss, or violent/sudden death. Shear's Prolonged Grief Disorder Therapy (16 sessions) has demonstrated efficacy in multiple RCTs, outperforming interpersonal therapy for grief-specific symptoms. Neria et al. (2007) established that traumatic bereavement creates a \"complex synergy\" where trauma symptoms and grief symptoms mutually reinforce each other, requiring integrated treatment approaches.

Key Sources for This Week:

- Wolfelt, A. D. (2021). Reframing PTSD as Traumatic Grief. Companion Press.

- Wolfelt, A. D. (2004). Complicated Grief: How to Understand, Express, and Reconcile Your Especially Difficult Grief. Companion Press.

- Levin, J. (2020). The Traumatic Loss Workbook. Whole Person Associates.

- Hospice Foundation of America (2017). Shattered: Trauma and Grief. HFA.

- Prigerson, H. G. et al. (2021). Prolonged Grief Disorder. NEJM, 385, 2390\u20132400.

Nervous System Regulation Exercise: Containment Visualization

"This exercise is particularly useful when grief (or traumatic imagery) feels overwhelming. Close your eyes. Imagine a container \u2014 a box, a vault, a chest, a room with a heavy door. It can be any size, any material. Now imagine placing the most overwhelming feelings or images into that container. Close it. Lock it. Know that it's there \u2014 you're not denying it exists \u2014 but you're choosing when to open it."

> *Why this works: Containment is a standard stabilization technique from EMDR and phase-oriented trauma treatment. It gives the nervous system a sense of agency over overwhelming material. It doesn't eliminate the pain \u2014 it creates a boundary around it so the person can function between grief waves.*

"This is not suppression. Suppression says 'this doesn't exist.' Containment says 'this exists, and I will return to it when I'm resourced enough to do so.' Teach this to the person you're supporting if they're flooding between sessions or at work."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 4

Your Role as Supporter

What helps, what hurts, and what is not your job.

Session Objectives

- Identify the three supporter roles: witness, practical helper, and boundary-holder
- Learn what grieving people actually find helpful (research-based)
- Recognize common 'helping' behaviors that actually harm
- Establish what is NOT your responsibility

Supporter Checklist

[ ] Check-in: Which type of grief do you think you're seeing? Any shifts?
[ ] Teach the three supporter roles
[ ] Review the 'What Helps / What Hurts' research
[ ] Establish boundaries around what is and isn't your job
[ ] Complete Worksheet: My Supporter Role Inventory

Session Script

"We've spent three weeks building understanding. Now we get practical. What is your actual job here? What are you supposed to DO?"

Three Supporter Roles

"You have three roles, and they shift depending on what the griever needs in any given moment:"

*"Role 1: Witness. This is the hardest one. Dr. Joanne Cacciatore, in *Bearing the Unbearable*, calls this 'attending to the suffering of another without the need to change, fix, or alter it.' She founded the MISS Foundation after the stillbirth of her daughter and has spent decades researching what bereaved people actually need. The answer is almost always the same: presence without agenda."*

"Your job is to be present to their pain without trying to fix it, minimize it, or redirect it. To sit with them while they cry. To listen to the same story for the fifteenth time without saying 'you've told me this before.' To tolerate the discomfort of not being able to make it better."

"Role 2: Practical Helper. Grief destroys executive function. The griever may not be able to make decisions, cook meals, pay bills, or return phone calls. Your job is to do specific, concrete things without being asked. Not 'let me know if you need anything' \u2014 that puts the burden on them. Instead: 'I'm bringing dinner Tuesday. Do you want soup or pasta?'"

"Role 3: Boundary-Holder. This is the one nobody talks about. Your job is to protect the griever from well-meaning people who are making things worse \u2014 and to protect yourself from burning out. You are not their therapist. You are not available 24/7. You are not responsible for their healing."

What Actually Helps (Research-Based)

"Researchers have asked bereaved people what was most helpful from their support network. The answers are consistent:"

"Showing up repeatedly, not just in the first week. Grief support drops off dramatically after the funeral. The loneliest time is 3\u20136 months later, when everyone else has moved on."

"Using the deceased's name. Sharing memories. Saying 'I was thinking about [name] today.' This tells the griever that the person they lost still exists in other people's minds."

"Tolerating silence. Not filling every moment with words. Sometimes the most powerful thing you can do is sit next to someone and say nothing."

"Following their lead. Some days they want to talk about the death. Some days they want to watch a stupid movie and not think about it. Let them choose."

What Hurts (Even When Well-Intentioned)

"Platitudes. 'They're in a better place.' 'Everything happens for a reason.' 'At least they're not suffering anymore.' 'God needed another angel.' Every bereaved person I've ever worked with has a list of things people said that made them want to scream."

"Comparing losses. 'I know how you feel \u2014 my dog died last year.' Unless you've lost the same type of relationship in similar circumstances, you don't know how they feel. And even then, grief is individual."

"Rushing the timeline. 'It's been six months, maybe you should...' 'Don't you think it's time to...' 'You need to move on for the kids.' Grief has no deadline. Stop imposing one."

"Avoiding them. Crossing the street because you don't know what to say. Not calling because you're afraid of 'reminding them.' They notice. And it tells them their grief has made them untouchable."

"Making it about you. 'This is so hard for ME to watch.' 'I just can't handle seeing you like this.' Your discomfort is real, but it's not their problem to manage."

What Is NOT Your Job

"You are not their therapist. If they need professional help \u2014 especially for complicated or traumatic grief \u2014 your job is to encourage it, not to provide it."

"You are not responsible for their healing. They will heal (or not) on their own timeline, through their own process. You can support it. You cannot control it."

"You are not available 24/7. You need sleep, boundaries, and your own life. A burned-out supporter is no help to anyone."

"You are not the grief police. You don't get to decide if they're grieving 'correctly,' 'too much,' or 'not enough.' Their grief is theirs."

> *What the Research Shows*
>
> *A 2020 systematic review in Bereavement Care (Djuric et al.) found that the most consistently helpful supporter behaviors were: consistent presence over time, willingness to listen without advising, practical help with daily tasks, and using the deceased's name in conversation. The most consistently harmful were: platitudes, timeline-imposing, avoidance, and comparing losses. Notably, supporters who received psychoeducation about grief provided significantly better support than those who relied on intuition alone.*
>
> *Key Sources for This Week:*
> *- Cacciatore, J. (2017). Bearing the Unbearable: Love, Loss, and the Heartbreaking Path of Grief. Wisdom Publications.*
> *- Wolfelt, A. D. (2005). Companioning the Bereaved. Companion Press.*

Nervous System Regulation Exercise: Vagal Toning (Extended Exhale)

"This one is simple and you can do it anywhere. Breathe in for a count of 4. Breathe out for a count of 6\u20138. The exhale should be longer than the inhale. That's it."

> *Why this works: The extended exhale directly stimulates the vagus nerve, shifting the autonomic nervous system from sympathetic activation (fight/flight) toward parasympathetic (rest/digest). This is particularly useful after difficult interactions with the griever, when your own nervous system has been activated by their pain.*

"Do this before you walk into their house. Do this after you leave. Do this in the car. It takes 30 seconds and it resets your nervous system so you can show up regulated."

Compassionate Inquiry Exercise

"Before we close, let's sit with a question from Gabor Mat\u00e9's Compassionate Inquiry framework. This isn't about the person you're supporting \u2014 it's about you."

> *CI Exercise: What Am I Trying to Fix?*
>
> *When I try to help [name] with their grief, the feeling I'm actually trying to get rid of is _____. I first learned that this feeling was intolerable when _____.*

"Write it down. Don't judge it. Most of us 'help' others partly because we can't tolerate our own helplessness. That's not shameful \u2014 it's human. But seeing it clearly lets you choose a different response."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 5
Holding Space Without Fixing

The art of presence \u2014 learning to be with pain without trying to make it go away.

Session Objectives

- Understand what 'holding space' actually means in practice
- Learn the difference between empathy and sympathy (and why it matters)
- Practice reflective listening without advice-giving
- Recognize your own 'fix-it' impulse and what drives it

Supporter Checklist

[ ] Check-in: How did the supporter role inventory land? Any surprises?
[ ] Teach the concept of holding space (presence without agenda)
[ ] Practice reflective listening responses
[ ] Identify your fix-it triggers
[ ] Complete Worksheet: Reflective Listening Practice

Session Script

*"This week is about the single hardest skill in grief support: being present to someone's pain without trying to make it go away. Megan Devine, in *It's OK That You're Not OK*, puts it bluntly: 'Some things in life cannot be fixed. They can only be carried.' Our culture trains us to fix problems. Grief is not a problem to fix. It's a process to accompany."*

What 'Holding Space' Actually Means

"Holding space means: I am here. I see your pain. I am not afraid of it. I am not trying to change it. I am not going anywhere. That's it. No advice. No silver linings. No redirection. Just presence."

"This is profoundly countercultural. We are trained from childhood that when someone is hurting, we should DO something. Say something helpful. Offer a solution. Find the bright side. In grief, all of that is noise. The signal is: I am here and I can handle this."

Empathy vs. Sympathy

"Bren\u00e9 Brown makes a distinction that matters here. Sympathy says 'I feel sorry for you' \u2014 it looks down from above. Empathy says 'I'm with you in this' \u2014 it climbs down into the hole."

"Sympathy sounds like: 'Oh, that's terrible. I'm so sorry.' (Then changes the subject.) Empathy sounds like: 'I can't imagine how heavy this is. I'm here.' (Then stays.)"

"Sympathy is about YOUR discomfort with their pain. Empathy is about THEIR experience of being seen in it."

Reflective Listening (Not Advice-Giving)

"When the griever talks, your job is to reflect, not redirect. Here's the formula:"

"They say: 'I just can't believe he's gone. I keep expecting him to walk through the door.' You reflect: 'Part of you still can't take it in that he's really gone.' NOT: 'Have you tried journaling about it?' NOT: 'It takes time.' NOT: 'He's in a better place.'"

"They say: 'I'm so angry. Why didn't the doctors catch it sooner?' You reflect: 'You're furious that this might have been preventable.' NOT: 'You can't change the past.' NOT: 'The doctors did their best.' NOT: 'Anger is a stage of grief.'"

"They say: 'I don't know who I am anymore without her.' You reflect: 'You're lost without the person who helped you know yourself.' NOT: 'You'll find yourself again.' NOT: 'You're still you.' NOT: 'Maybe this is a chance to reinvent yourself.'"

"Notice the pattern: Reflect the feeling. Name what you hear. Don't add. Don't fix. Don't future-cast."

Your Fix-It Impulse

"When you feel the urge to offer advice, ask yourself: Am I doing this for them, or for me? Usually, advice-giving in grief is about the supporter's inability to tolerate helplessness. We give advice because sitting in 'I can't make this better' is unbearable."

"The paradox: When you stop trying to fix their grief, they feel more supported than when you were working overtime to help. Because what they need is not a solution. They need a witness."

"Devine writes about the 'hierarchy of grief' \u2014 the way our culture ranks losses and tells people whether their grief is 'justified.' Miscarriage vs. stillbirth. Grandparent vs. child. Expected vs. sudden. This ranking is violence. All grief is valid. Your job is not to assess whether their grief is proportional. Your job is to honor it."

The 'Move With' Reframe

"Here's the single most important reframe for you as a supporter: your job is not to help them 'move on.' It's to help them 'move with.' Jim Carrey put it simply ~ instead of moving on from grief, one learns to move with it. The pain softens over time while the love transforms. You are not helping them leave something behind. You are helping them carry something forward."

"Queen Elizabeth II said: 'Grief is the price we pay for love.' John Pavlovitz called it 'the tax on loving people ~ a necessary payment for the accrued capital gains of intimacy.' These aren't platitudes. They're reframes that honor the loss instead of pathologizing it. When you can hold this truth ~ that grief is not a problem but a testament ~ you stop trying to fix it. And that's when you become actually helpful."

"So when they're crying on the couch at 10 PM on a Tuesday six months after the death, and you feel the pull to say 'maybe you should talk to someone' or 'it might help to get out more' ~ pause. Ask yourself: Am I trying to move them ON? Or am I willing to move WITH them? The first is about your discomfort. The second is about their dignity."

> *What the Research Shows*
>
> *Neimeyer et al. (2010) found that the quality of social support \u2014 not the quantity \u2014 predicted grief outcomes. Specifically, support characterized by \"empathic presence\" (being with, not doing for) was associated with better adaptation, while support characterized by \"directive guidance\" (advice-giving, timeline-imposing) was associated with worse outcomes and social withdrawal by the griever. The griever's perception of being understood mattered more than any specific intervention.*
>
> *Key Sources for This Week:*
> *- Devine, M. (2017). It's OK That You're Not OK: Meeting Grief and Loss in a Culture That Doesn't Understand. Sounds True.*
> *- Neimeyer, R. A. et al. (2010). Grief Therapy and the Reconstruction of Meaning. Journal of Contemporary Psychotherapy, 40(2), 73\u201383.*

Nervous System Regulation Exercise: Co-Regulation Through Breath

"This exercise is for when you're WITH the griever and they're dysregulated. Don't announce it. Don't say 'let's do a breathing exercise.' Just slow your own breathing. Breathe audibly \u2014 a slightly louder exhale than normal. Their nervous system will unconsciously begin to match yours. This is co-regulation."

> *Why this works: Mirror neurons and the social engagement system (ventral vagal complex) are designed to synchronize with nearby regulated nervous systems. When you regulate yourself in the presence of a dysregulated person, you become an external regulator for them \u2014 without saying a word.*

"This only works if YOU are actually regulated. If you're activated by their pain, your fast breathing and tense body will dysregulate them further. Regulate yourself first. Then be near them."

Compassionate Inquiry Exercise: Being With Pain Without Fixing

"Gabor Maté's Compassionate Inquiry framework asks us to approach suffering with curiosity rather than correction. The core question is not 'How do I make this better?' but 'What is this person experiencing right now, and can I be present to it without needing it to change?'"

"Here's a practice you can do before visiting or calling the griever:"

Step 1 ~ Ground yourself. Feet on the floor. Three slow breaths. Notice your own body. Are you braced? Tense? Already rehearsing what you'll say? Let that go.

Step 2 ~ Set your intention. Say silently: 'I am here to witness, not to fix. Their pain does not require my solution. My presence is enough.'

Step 3 ~ Notice your discomfort. When you're with them and the silence stretches, or the tears come, or they say something that makes you want to jump in ~ notice the sensation in YOUR body. Tightness in the chest? Urge to speak? That's YOUR discomfort with helplessness. Name it: 'This is my fix-it impulse. It's about me, not them.'

Step 4 ~ Stay anyway. Don't fill the silence. Don't redirect. Don't offer a tissue (unless they reach for one). Just breathe. Be there. Let the pain exist in the room without anyone trying to make it smaller.

Step 5 ~ Reflect afterward. Ask yourself: 'What did I feel when I couldn't fix it? What did I want to do? What did I actually do?' Write it down. This is how you build tolerance for being with suffering ~ the single most important skill in grief support.

> *Why this works: Compassionate Inquiry (Maté, 2022) recognizes that the impulse to fix others' pain often originates in our own unresolved relationship with suffering. When we can be present to pain without needing to eliminate it, we communicate something words cannot: 'You are not too much. Your grief is not a problem. You are safe to feel this here.' That message ~ delivered through regulated presence rather than advice ~ is what actually helps.*

WEEK 6

Communication During Grief

What to say, what not to say, and when silence is the answer.

Session Objectives

- Learn specific language that helps vs. language that harms
- Understand why grievers stop talking to people (and how to prevent it)
- Practice initiating contact without pressure
- Develop a communication rhythm that respects their oscillation

Supporter Checklist

[ ] Check-in: How did reflective listening go this week? What was hard?
[ ] Review harmful vs. helpful language (with specific examples)
[ ] Practice low-pressure check-in messages
[ ] Discuss communication frequency and rhythm
[ ] Complete Worksheet: My Communication Plan

Session Script

"Communication is where most supporters fail. Not because they're bad people \u2014 because they've never been taught what to say to someone in grief. This week we get specific."

Language That Helps

"Here are phrases that grieving people consistently report as helpful:"

"'I'm thinking about you and [name] today.' \u2014 This uses the deceased's name. It tells them the person is remembered."

"'You don't have to respond to this. Just know I'm here.' \u2014 This removes the burden of performing gratitude or reassurance."

"'I don't know what to say. But I'm not going anywhere.' \u2014 Honesty about your own limitations is more comforting than a polished platitude."

"'What do you need right now \u2014 company, space, or distraction?' \u2014 This gives them agency without putting the burden of initiation on them."

"'I remember when [name] [specific memory].' \u2014 Sharing a specific memory tells them the person existed in your world too."

Language That Harms

*"Megan Devine calls these 'grief illiterate' responses \u2014 things people say with good intentions that land like grenades. In *It's OK That You're Not OK*, she catalogs the damage done by well-meaning people who cannot tolerate another person's pain:"*

"'I know how you feel.' \u2014 You don't. Even if you've experienced a similar loss, grief is individual. Say instead: 'I can't fully understand what this is like for you, but I'm here.'"

"'At least...' \u2014 'At least she lived a long life.' 'At least he's not in pain anymore.' 'At least you have other children.' Every sentence that starts with 'at least' minimizes their loss."

"'You're so strong.' \u2014 This tells them their grief is only acceptable if it's contained. It punishes visible pain. Say instead: 'You don't have to be strong with me.'"

"'Call me if you need anything.' \u2014 They won't call. Grief destroys initiative. Instead, offer something specific: 'I'm coming over Thursday at 6 with food. You don't have to be social.'"

"Silence \u2014 the absence of contact. Not reaching out because you 'don't want to bother them' or 'don't know what to say.' They notice. And they interpret it as abandonment."

Why Grievers Stop Talking to People

"Grieving people often withdraw from their support network. Not because they don't need support \u2014 because the cost of receiving support becomes too high. They have to manage YOUR emotions about their grief. They have to reassure YOU that they're okay. They have to perform gratitude for help that doesn't actually help."

"If the person you're supporting has gone quiet, it might mean they're overwhelmed. But it might also mean that interacting with their support network has become another task on an impossible list. Your job: make contact easy and expectation-free."

Low-Pressure Check-Ins

"Text > call for most grievers. A text doesn't demand immediate response. Examples:"

"'Thinking of you. No response needed.' 'Saw [thing that reminded me of name]. Made me smile.' 'I'm at the grocery store. Can I grab you anything?' 'Just checking in. You don't have to be okay.'"

"Send these regularly. Weekly minimum. Don't stop after the first month. The loneliest time in grief is 3\u20136 months after the death, when everyone else has moved on."

> *What the Research Shows*

Breen and O'Connor (2011) found that perceived social support quality \u2014 not quantity \u2014 predicted grief outcomes at 6 and 12 months. Bereaved individuals who reported feeling \"understood\" by at least one person had significantly lower rates of complicated grief. Conversely, those who reported \"unhelpful\" support (platitudes, avoidance, timeline-imposing) had worse outcomes than those who reported NO support \u2014 suggesting that bad support is worse than no support.

> *Key Sources for This Week:*

- Devine, M. (2017). It's OK That You're Not OK. Sounds True. (Chapters 7\u201310 on communication.)

- Breen, L. J. & O'Connor, M. (2011). Social Support and Grief Outcomes. Death Studies, 35(5), 421\u2013440.

Nervous System Regulation Exercise: Orienting

"When you notice yourself getting anxious about what to say or how to show up, try this: Slowly turn your head and look around the room. Name what you see. 'There's the blue chair. There's the window. There's the plant.' Let your eyes rest on anything that feels neutral or pleasant."

Why this works: Orienting is a fundamental nervous system reset. It engages the social engagement system (turning the head activates neck muscles innervated by the ventral vagal complex) and signals to the brainstem that the environment is safe. It interrupts the freeze response that often accompanies social anxiety.

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 7

Grief Triggers & Anniversaries

Supporting through holidays, anniversaries, and unexpected sensory reminders.

Session Objectives

- Understand why grief 'comes back' at specific times
- Learn to anticipate and prepare for grief triggers
- Develop a plan for the first anniversary, holidays, and birthdays
- Recognize unexpected triggers (sensory, situational, developmental)

Supporter Checklist

[ ] Check-in: How is your communication plan working?
[ ] Teach the concept of grief triggers (expected and unexpected)
[ ] Plan for upcoming anniversaries or holidays
[ ] Discuss 'grief bursts' and how to respond
[ ] Complete Worksheet: Trigger Anticipation & Support Plan

Session Script

"Grief doesn't follow a straight line downward. It comes in waves \u2014 and some of those waves are predictable. This week we learn to anticipate them."

Expected Triggers

"Some grief triggers are obvious: the anniversary of the death, the deceased's birthday, holidays they used to celebrate together, the song that played at the funeral, the restaurant where they always ate."

"Here's what supporters often miss: The anticipation of the trigger is often worse than the day itself. The week BEFORE the anniversary may be harder than the anniversary. The griever is bracing. Your job is to acknowledge the approaching date, not pretend it isn't coming."

"Say: 'I know Tuesday is the one-year mark. I'm thinking about you. Do you want company, or do you want space? Either is fine.' Don't wait for them to bring it up. Don't assume they want to be alone. Don't assume they want company. Ask."

Unexpected Triggers

"These are the ones that ambush. A stranger wearing the same cologne. A song on the radio. Seeing someone who looks like the deceased from behind. The smell of the hospital. A child the same age their child would have been."

"The griever can't predict these. Neither can you. But you can normalize them: 'Grief doesn't ask permission. It shows up when it shows up. That doesn't mean you're going backward.'"

"If you're with them when a grief burst hits: Don't panic. Don't try to distract them. Don't say 'are you okay?' (they're clearly not). Say: 'I'm here. Take your time.' Then be quiet."

The First Year

"The first year of grief is a minefield of 'firsts.' First birthday without them. First holiday. First family gathering with an empty chair. First time doing something they always did together \u2014 alone."

"Each 'first' reopens the wound. This is normal. It doesn't mean the grief is getting worse. It means the griever is encountering new dimensions of the absence. Each first is a new loss within the larger loss."

"Your job during firsts: Be proactive. Don't wait to be asked. 'I know Thanksgiving is coming up and this will be the first one without [name]. What would feel right to you? Do you want to keep traditions, change them, or skip it entirely? I'll support whatever you choose.'"

After the First Year

"Here's what nobody tells supporters: The second year can be harder than the first. In the first year, there's a kind of shock buffer. The numbness hasn't fully worn off. By year two, the reality has fully landed \u2014 and the support network has disappeared."

"Keep showing up. Keep using the name. Keep acknowledging the dates. Grief doesn't expire."

> *What the Research Shows*
>
> *Bonanno et al. (2002) documented the "anniversary reaction" \u2014 a measurable spike in grief symptoms around the anniversary of the death, even in people who are otherwise adapting well. This reaction is neurobiological, not pathological: the brain encodes traumatic/significant events with temporal markers, and approaching dates trigger implicit memory activation. Importantly, the anticipatory anxiety before the anniversary often exceeds the distress on the day itself.*

Nervous System Regulation Exercise: Havening Touch

"Havening is a self-soothing technique that uses gentle bilateral touch. Cross your arms and slowly stroke from your shoulders down to your elbows. Repeat for 30\u201360 seconds. Alternatively, gently stroke your palms or your forehead."

> *Why this works: Gentle, repetitive touch produces delta waves in the brain \u2014 the same waves present in deep sleep. This electrochemically depotentiates the amygdala's threat response, reducing the emotional charge of distressing content. It's particularly useful during grief bursts or anticipatory anxiety.*

"You can do this discreetly \u2014 stroking your own forearms under a table, for instance. Teach it to the person you're supporting as a self-soothing tool for when grief ambushes them in public."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 8

When Grief Looks Like Something Else

Recognizing grief disguised as anger, withdrawal, recklessness, or physical illness.

Session Objectives

- Understand that grief manifests differently across people and cultures
- Recognize grief disguised as anger, irritability, or rage
- Recognize grief disguised as withdrawal, numbness, or 'not caring'
- Recognize grief disguised as reckless behavior or substance use
- Learn to respond to the grief underneath the behavior

Supporter Checklist

[ ] Check-in: How did trigger planning go? Any surprises?
[ ] Teach grief's many disguises (anger, withdrawal, recklessness, somatic symptoms)
[ ] Practice responding to the grief underneath the behavior
[ ] Discuss gendered and cultural grief norms
[ ] Complete Worksheet: What's Underneath?

Session Script

"Not everyone grieves with tears. Some people grieve with fists. Some grieve by disappearing. Some grieve by drinking. Some grieve by working 80-hour weeks. This week we learn to see grief even when it doesn't look like grief."

"Joan Didion spent an entire year in what she called 'magical thinking' \u2014 she couldn't give away her husband's shoes because he would need them when he came back. She knew he was dead. She could not stop believing he would return. That's not denial in the K\u00fcbler-Ross sense. That's the brain's inability to update its predictive model. The neural circuits that expect the person to walk through the door don't get the memo for months. This is grief disguised as normalcy \u2014 the griever going through motions while their brain refuses to integrate the absence."

Grief Disguised as Anger

"Anger is one of the most common grief responses \u2014 and one of the least recognized. The griever might be furious at the doctors, at God, at the deceased for dying, at themselves for not preventing it, at you for being alive when their person isn't."

"If the person you're supporting is rageful, irritable, or picking fights \u2014 look underneath. Ask yourself: Is this anger, or is this grief that has no other outlet? Many people (especially men socialized to suppress sadness) can only access grief through anger. It's the one 'acceptable' intense emotion."

"Don't take it personally. Don't argue with the content of the anger. Reflect the feeling underneath: 'You're so angry. And underneath that anger, I think there's a lot of pain.' Then let them respond however they need to."

Grief Disguised as Withdrawal

"Some grievers go silent. They stop returning calls. They cancel plans. They sit in dark rooms. They say 'I'm fine' in a voice that makes it clear they're not."

"This might be dorsal vagal shutdown \u2014 the nervous system's collapse response. Or it might be social exhaustion \u2014 the cost of performing 'okay' for everyone has become too high. Or it might be complicated grief \u2014 the avoidance of anything that triggers the pain."

"Don't interpret withdrawal as rejection. Keep reaching out. Low-pressure, no-expectation contact. 'I'm here. You don't have to respond. I'm not going anywhere.' Consistency matters more than intensity."

Grief Disguised as Recklessness

"Some grievers engage in risky behavior: excessive drinking, drug use, unsafe sex, reckless driving, spending sprees, quitting their job impulsively. This is often an attempt to feel something other than grief \u2014 or to feel nothing at all."

"This is where your boundary-holder role becomes critical. You cannot control their behavior. But you can name what you see without judgment: 'I've noticed you're drinking more since [name] died. I'm not judging. I'm worried. Can we talk about it?'"

Grief Disguised as Physical Illness

"Grief lives in the body. Chest pain. Difficulty breathing. Exhaustion that sleep doesn't fix. Headaches. Digestive problems. Immune suppression (grievers get sick more often in the first year). These are not 'psychosomatic' in the dismissive sense \u2014 they are the physical manifestation of a nervous system under chronic stress."

"Encourage medical check-ups. Don't dismiss physical symptoms as 'just grief.' But also understand that many of these symptoms will resolve as the grief is processed. The body holds what the mind cannot yet integrate."

Gendered and Cultural Grief Norms

"Men are often socialized to grieve through action rather than emotion: fixing things, staying busy, solving problems. This is sometimes called 'instrumental grief.' It's not wrong \u2014 it's different. Don't pathologize someone for not crying if they're processing through doing."

"Cultural norms vary enormously. Some cultures have elaborate mourning rituals that last months. Others expect rapid return to function. Some encourage wailing; others value stoicism. Ask the griever what their cultural or family norms are \u2014 and whether those norms are helping or constraining them."

> *What the Research Shows*
>
> *Doka (2002) introduced the concept of \"disenfranchised grief\" \u2014 grief that is not socially acknowledged or supported. This includes grief after stigmatized deaths (suicide, overdose), grief by non-traditional relationships (ex-partners, affair partners, online friends), and grief expressed in non-normative ways (anger, recklessness, silence). Disenfranchised grief is a significant risk factor for complicated grief because the griever lacks social permission to mourn.*
>
> *Key Sources for This Week:*
> *- Didion, J. (2005). The Year of Magical Thinking. Knopf.*
> *- Doka, K. J. (2002). Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice. Research Press.*

Nervous System Regulation Exercise: Progressive Muscle Relaxation (Abbreviated)

"When grief manifests as physical tension \u2014 clenched jaw, tight shoulders, stomach knots \u2014 try this abbreviated version: Clench your fists as tight as you can for 5 seconds. Release. Notice the contrast. Now shrug your shoulders to your ears for 5 seconds. Release. Now clench your jaw for 5 seconds. Release."

> *Why this works: The deliberate tension-release cycle activates the parasympathetic nervous system through the contrast principle. The body cannot maintain both tension and relaxation simultaneously. By intentionally creating and releasing tension, you signal safety to the brainstem.*

"This is particularly useful for grief that shows up as anger or physical agitation. The body needs to discharge the activation before the mind can process."

WEEK 9

Your Own Grief & Secondary Loss

Acknowledging that supporting a griever changes you \u2014 and costs you something.

Session Objectives

- Recognize your own grief (you lost something too)
- Understand secondary losses (the relationship changes, the future you imagined)
- Learn to grieve while supporting someone else's grief
- Identify signs of compassion fatigue in yourself

Supporter Checklist

[ ] Check-in: What behaviors have you been seeing? What's underneath?
[ ] Acknowledge your own losses in this situation
[ ] Teach the concept of secondary loss
[ ] Assess for compassion fatigue
[ ] Complete Worksheet: My Losses in This

Session Script

"We've spent eight weeks focused on the person you're supporting. This week we turn the lens on you. Because here's what nobody says: You are also grieving. Not the same grief. But grief nonetheless."

Your Grief Is Real

"If the person who died was also someone you knew and loved \u2014 a parent, a friend, a family member \u2014 you are grieving that loss while simultaneously supporting someone else's grief. Your grief gets pushed aside because theirs is 'bigger.' But grief is not a competition. Your loss is real."

"Even if you didn't know the deceased, you are grieving the person you're supporting. The version of them that existed before this loss is gone. The relationship you had with them has changed. The future you imagined together has been altered. These are real losses."

Secondary Losses

"Every death creates a cascade of secondary losses that nobody talks about:"

"Loss of the relationship as it was. Your friend who used to be the life of the party is now someone who cancels plans and cries on your couch. You miss who they were before."

"Loss of your own emotional freedom. You can't talk about your problems because theirs are 'worse.' You can't be happy around them without feeling guilty. You've lost the right to your own full emotional range."

"Loss of the future you imagined. If your partner lost a parent, you've lost the grandparent your children would have had. If your friend lost a spouse, you've lost the couple you used to double-date with."

"These losses are disenfranchised \u2014 nobody acknowledges them. But they're real, and they need to be grieved."

Compassion Fatigue

"Compassion fatigue is the cost of caring. It's not burnout (which is about workload). It's the emotional depletion that comes from absorbing someone else's pain over time. Signs include:"

"Dreading contact with the griever. Feeling irritable or resentful when they reach out. Emotional numbness \u2014 you can't feel anything anymore. Physical exhaustion that rest doesn't fix. Intrusive thoughts about death or loss. Withdrawal from your own relationships."

"If you're experiencing these: You are not a bad person. You are a person who has been giving without replenishing. You need your own support \u2014 a friend, a therapist, a support group for caregivers. You cannot sustain this alone."

*"Joanne Cacciatore writes in *Bearing the Unbearable* about what she calls 'attending' \u2014 the practice of being fully present to suffering without armoring against it. But she's also clear: attending requires a container. You cannot hold space for someone else's grief if your own container is cracked. Repairing your container is not selfish. It's structural. It's the thing that makes your presence sustainable rather than sacrificial."*

> *What the Research Shows*

> *Figley (1995) defined compassion fatigue as \"the cost of caring for others in emotional pain.\" A 2019 meta-analysis in Death Studies found that informal caregivers of bereaved individuals showed elevated cortisol, disrupted sleep, and increased rates of depression \u2014 particularly when they suppressed their own grief to prioritize the bereaved person's needs. The protective factors were: having their own support network, setting boundaries, and acknowledging their own losses.*

> *Key Sources for This Week:*
> *- Cacciatore, J. (2017). Bearing the Unbearable. Wisdom Publications. (Chapter on \"Attending\" and self-care for supporters.)*

> *- Figley, C. R. (1995). Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder. Brunner/Mazel.*

Nervous System Regulation Exercise: Self-Compassion Break (Kristin Neff)

"When you notice compassion fatigue or self-judgment about your own needs, try this three-step practice:"

"Step 1: Acknowledge the suffering. 'This is hard. I'm hurting too.' Step 2: Common humanity. 'Other people in my position would feel this way. I'm not alone in this.' Step 3: Self-kindness. 'May I be gentle with myself. May I give myself what I need.'"

> *Why this works: Neff's research demonstrates that self-compassion activates the mammalian caregiving system (oxytocin, endorphins) rather than the threat system (cortisol, adrenaline). It literally changes the neurochemistry of self-relating, reducing the shame spiral that often accompanies caregiver exhaustion.*

Compassionate Inquiry Exercise: Turning the Lens Inward

"In Week 5, we used Compassionate Inquiry to be present with the griever's pain. This week, we turn it inward. The same framework applies to YOUR suffering ~ approaching your own grief, fatigue, and resentment with curiosity rather than judgment."

"Find 10 minutes alone. No phone. No distractions."

Step 1 ~ Ask yourself: 'What am I carrying right now that I haven't named?' Don't censor. Don't rank it against the griever's loss. Just notice. Maybe it's exhaustion. Maybe it's anger. Maybe it's grief for the relationship you had before death changed everything.

Step 2 ~ Ask: 'What does this feeling need from me?' Not what does the GRIEVER need. What does YOUR pain need? Rest? Acknowledgment? Permission to exist? A conversation with someone who asks about YOU?

Step 3 ~ Ask: 'What story am I telling myself about having this feeling?' Common stories: 'I shouldn't feel this way ~ their loss is bigger.' 'I'm being selfish.' 'Good supporters don't get tired.' Name the story. Then ask: 'Is this story true? Or is it a rule I absorbed from a culture that doesn't understand caregiver grief?'

Step 4 ~ Offer yourself the same sentence you'd offer the griever: 'This is real. This matters. You don't have to perform okay.'

> *Why this works: Maté (2022) emphasizes that compassion for others becomes unsustainable without compassion for self. Supporters who suppress their own grief to prioritize the bereaved person's needs show elevated cortisol, disrupted sleep, and increased depression (Figley, 1995). This exercise interrupts the suppression pattern by making your own experience visible ~ to yourself ~ without requiring anyone else's permission or validation.*

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 10

When to Encourage Professional Help

Recognizing Prolonged Grief Disorder, suicidality, and the limits of lay support.

Session Objectives

- Learn the DSM-5-TR criteria for Prolonged Grief Disorder
- Recognize suicidal ideation in grieving people
- Know how to have the 'I think you need more help than I can give' conversation
- Understand what grief therapy looks like (so you can explain it)

Supporter Checklist

[ ] Check-in: How are YOUR losses landing? Any compassion fatigue?
[ ] Review PGD criteria and red flags
[ ] Practice the 'encouraging professional help' conversation
[ ] Discuss what grief therapy actually involves
[ ] Complete Worksheet: Professional Help Decision Tree

Session Script

"This week we talk about the limits of what you can do \u2014 and when the person you're supporting needs more than a devoted friend or family member can provide."

When Normal Grief Becomes Prolonged Grief Disorder

"Remember from Week 3: Prolonged Grief Disorder is diagnosed when grief remains intense, preoccupying, and functionally impairing beyond 12 months. The key markers:"

"The pain hasn't softened. At 14, 18, 24 months \u2014 it's as raw as it was in the first weeks. There's no oscillation. They're stuck in loss-orientation with no movement toward restoration."

"They cannot integrate the reality. They still can't believe the person is dead. They still expect them to come home. The intellectual knowing and the embodied knowing haven't converged."

"They've lost their identity. They don't know who they are without the deceased. They can't imagine a future. They feel that a part of themselves died with the person."

"They're avoiding everything. Not just painful reminders \u2014 ALL reminders. They've removed photos, avoid mutual friends, won't go to places they went together. The avoidance has become total."

Recognizing Suicidal Ideation in Grief

"Grief and suicidal thinking often coexist. The griever may say things like 'I want to be with them' or 'I can't do this without them' or 'What's the point?' These statements exist on a spectrum:"

"Passive ideation: 'I wish I could just go to sleep and not wake up.' 'If I got hit by a bus, that would be fine.' This is common in acute grief and doesn't always indicate imminent risk \u2014 but it needs to be taken seriously."

"Active ideation: 'I've been thinking about how to do it.' 'I've been saving pills.' 'I wrote a letter.' This is a crisis. This requires immediate professional intervention."

"If you hear active ideation: Don't panic visibly. Don't leave them alone. Say: 'I hear you. I'm taking this seriously. I'm going to help you get help right now.' Call 988 (Suicide & Crisis Lifeline) or take them to the nearest ER."

Having the Conversation

"The hardest sentence in grief support: 'I think you need more help than I can give.' Here's how to say it without it landing as abandonment:"

"'I love you and I'm not going anywhere. AND I think what you're going through is bigger than what I can hold alone. I want you to have someone with training in this \u2014 not because I'm giving up, but because you deserve specialized support.'"

"'I've noticed that [specific observation \u2014 not sleeping, not eating, the pain isn't softening, you mentioned wanting to die]. I'm not qualified to help with that. But I know people who are. Can we look into it together?'"

"Offer to help with logistics: finding a therapist, making the call, driving them to the appointment. The executive function required to seek help is often destroyed by grief."

What Grief Therapy Looks Like

"If they ask 'what would therapy even do?' \u2014 here's what you can tell them:"

"For Prolonged Grief Disorder: Shear's PGD Therapy is 16 sessions. It helps the griever process the reality of the loss, reduce avoidance, rebuild a sense of purpose, and develop a continuing bond with the deceased. It's structured, time-limited, and evidence-based."

*"For Traumatic Grief: EMDR or CPT can process the traumatic aspects of the death so that the natural grief process can resume. Once the trauma is addressed, the griever can think about the person without being flooded by images of how they died. Wolfelt's *Reframing PTSD as Traumatic Grief* argues that this is not two separate conditions requiring two separate treatments \u2014 it's one condition (traumatic grief) that requires an integrated approach."*

"There's also a specialized EMDR protocol worth knowing about: Induced After-Death Communication (IADC), developed by Allan Botkin. In a study of 83 cases, Botkin found that a modified EMDR protocol \u2014 using bilateral stimulation during grief processing rather than trauma processing \u2014 facilitated experiences of connection with the deceased in approximately 70-80% of participants. These experiences were associated with significant reductions in grief, sadness, and anger. This is not mainstream yet, but it's published, it's replicable, and it suggests that EMDR's applications in grief extend beyond trauma processing."

"For general grief support: Individual therapy, grief groups, or both. The key is finding someone trained in grief \u2014 not all therapists are."

> *What the Research Shows*

> *Shear et al. (2005, 2014) demonstrated that Complicated Grief Treatment (now PGD Therapy) produced response rates of 51% vs. 28% for interpersonal therapy in a landmark RCT. A 2024 systematic review (Srivastava et al.) across 30 RCTs confirmed that grief-focused CBT and PGD Therapy are the most effective interventions, with effect sizes comparable to those seen in PTSD treatment. Importantly, untreated PGD is associated with increased cardiovascular disease, cancer, substance use disorders, and suicide.*

> *Key Sources for This Week:*

> *- Botkin, A. L. (2000). The Induction of After-Death Communications Utilizing EMDR: A New Discovery. Journal of Near-Death Studies, 18(3), 181\u2013209.*

> *- Wolfelt, A. D. (2021). Reframing PTSD as Traumatic Grief. Companion Press.*

> *- Shear, M. K. et al. (2014). Complicated Grief Treatment. JAMA Psychiatry, 71(11), 1287\u20131295.*

Nervous System Regulation Exercise: Safe Place Visualization

"This is a classic stabilization technique from EMDR. Close your eyes. Imagine a place \u2014 real or imagined \u2014 where you feel completely safe. It might be a beach, a room, a forest, a memory. Notice what you see, hear, smell, and feel in this place. Let your body settle into the safety of it. Stay for 60 seconds."

> *Why this works: Safe place visualization activates the ventral vagal system and creates a neurological 'anchor' that can be accessed during distress. With practice, simply bringing the image to mind can shift the nervous system toward regulation. This is useful for both you and the person you're supporting.*

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 11

Meaning-Making & Continuing Bonds

Supporting the griever in finding meaning and maintaining connection with the deceased.

Session Objectives

- Understand meaning-making in grief (not 'finding a silver lining')
- Learn the Continuing Bonds framework
- Support rituals, legacy projects, and ongoing connection
- Recognize when meaning-making is premature vs. organic

Supporter Checklist

[ ] Check-in: Did you have the professional help conversation? How did it go?
[ ] Teach meaning-making (what it is and what it isn't)
[ ] Introduce Continuing Bonds theory
[ ] Discuss rituals and legacy projects
[ ] Complete Worksheet: Supporting Meaning & Connection

Session Script

"As grief evolves \u2014 and it does evolve, even when it doesn't disappear \u2014 many grievers begin to search for meaning. This week we learn how to support that search without forcing it."

What Meaning-Making Is (And Isn't)

"Meaning-making in grief is NOT finding a silver lining. It's not 'everything happens for a reason.' It's not 'they're in a better place.' It's not toxic positivity dressed up as wisdom."

"Meaning-making is the griever's own process of integrating the loss into their life story. It might sound like: 'Because of losing her, I now understand what matters.' Or: 'His death changed how I live \u2014 I don't take time for granted.' Or: 'I can't make sense of why this happened, but I can choose what I do with the rest of my life.'"

"This cannot be rushed. It cannot be imposed from outside. If you say 'maybe something good will come from this' before the griever is ready, it will land as dismissal. Meaning-making is something the griever arrives at \u2014 not something you deliver to them."

"Your job: When you hear them beginning to make meaning \u2014 even tentatively \u2014 reflect it back. 'It sounds like you're starting to see how this changed you.' Don't add to it. Don't amplify it. Just witness it."

Continuing Bonds

"The old model of grief said the goal was 'letting go' \u2014 detaching from the deceased and 'moving on.' Klass, Silverman, and Nickman (1996) overturned this with Continuing Bonds theory: Healthy grief doesn't end the relationship. It transforms it."

"The deceased remains part of the griever's life \u2014 through memory, through legacy, through internalized values, through ongoing 'conversations,' through rituals. This is not pathological. This is adaptive. The griever doesn't 'get over' the person. They learn to carry them differently."

"Your job: Don't discourage continuing bonds. If the griever talks to the deceased, keeps their belongings, visits the grave regularly, celebrates their birthday \u2014 this is not 'being stuck.' This is maintaining connection. Support it."

"A note on after-death communications (ADCs): Many grievers report spontaneous experiences of connection with the deceased \u2014 sensing their presence, hearing their voice, dreaming of them, smelling their perfume. Research by Botkin (2000) using EMDR protocols found that these experiences can also be therapeutically facilitated, and when they occur \u2014 whether spontaneous or induced \u2014 they're associated with significant reductions in grief intensity. If the person you're supporting reports these experiences, do NOT pathologize them. Don't say 'that's just your brain playing tricks.' Say: 'Tell me about it.' These experiences are reported by 40-60% of bereaved people across cultures. They are normative, not psychotic."

Rituals & Legacy Projects

"Research confirms that rituals help people process grief, remain resilient against emotional distress, and regain a sense of control over a world that no longer makes sense without the deceased. Most people think 'ritual' means funerals and wearing black. But there's a vast bank of private, personal rituals that help maintain an enduring connection with the deceased while also reinvesting energy in new life."

"The key insight: One never has to give up the relationship with the deceased. One has to do the work to transform it. Here are concrete rituals you can suggest ~ gently, only when the griever seems to be searching for something to do with their grief:"

Personal Rituals for Staying Connected:

"Create an altar in the home ~ photos, candles, totems, flowers, objects that carry their energy. Light a candle at specific times (dinner, bedtime, Sunday mornings) to represent their continued presence. Create a memory box or scrapbook filled with photos, letters, notes, and memorabilia. Listen to their favorite music or watch their favorite movie. Plant a tree or garden in their memory. Carry a totem ~ a worry stone, piece of jewelry, something you can hold when it gets hard. Create art in their memory ~ painting, writing, music,

crafting. Prepare and eat their favorite meal. Get a meaningful tattoo to ritualize and process the grief. Make a quilt from their clothing. Research their ancestry ~ dive into their past, their family tree, their history."

Ways to Communicate With the Deceased:

"Write a letter. Keep it, burn it, float it in a river. Send a helium balloon with notes written on rice paper inside. Talk out loud to them ~ in the car, at their grave, in the kitchen. Keep a journal addressed to them. These are not signs of 'not letting go.' These are healthy continuing bonds in action."

Ritual Ideas for Holidays and Special Dates:

"On birthdays, bake their favorite meal and gather friends for a celebration of their memory. On holidays, acknowledge their presence ~ light a candle, set a place at the table, have everyone share a memory. On Christmas, hang a stocking for them, buy one new ornament each year in their memory. Purchase a gift for them and donate it. And here's the permission slip: you can return to old traditions, change them, eliminate some, or create entirely new ones. There is no 'right way' to celebrate holidays after loss."

"Your job as supporter: Participate when invited. Suggest gently if they seem to be searching. But don't push. Some people don't need external rituals. Some carry their continuing bond internally and that's enough."

When Meaning-Making Is Premature

"If someone is trying to find meaning in the first weeks or months, they might be bypassing the pain rather than processing it. Meaning-making that comes too early is often a defense against feeling the full weight of the loss."

"Signs of premature meaning-making: 'I'm grateful for the time we had' (said with a tight smile and no tears). 'They would want me to be happy' (said while clearly not happy). 'I've accepted it' (said 6 weeks after the death)."

"This isn't wrong \u2014 but it might be incomplete. The griever may need permission to NOT be okay yet. You can gently offer: 'You don't have to have made peace with this yet. It's okay to still be in the middle of it.'"

> *What the Research Shows*
>
> *Neimeyer (2001) demonstrated that meaning-making is one of the strongest predictors of positive grief outcomes \u2014 but only when it emerges organically from the griever's own process. Externally imposed meaning ('God has a plan') was associated with worse outcomes. Klass et al. (1996) showed that maintaining continuing bonds with the deceased was normative across cultures and associated with better long-term adaptation, overturning decades of clinical advice to 'let go.' Botkin (2000) found that EMDR-facilitated after-death*

communications produced lasting reductions in grief, sadness, and anger in 70-80% of participants, suggesting that continuing bonds can be actively supported through therapeutic intervention.

>

Key Sources for This Week:

- Klass, D., Silverman, P. R. & Nickman, S. (1996). Continuing Bonds: New Understandings of Grief. Taylor & Francis.

- Botkin, A. L. (2000). The Induction of After-Death Communications Utilizing EMDR. Journal of Near-Death Studies, 18(3), 181\u2013209.

- Neimeyer, R. A. (2001). Meaning Reconstruction and the Experience of Loss. APA.

Nervous System Regulation Exercise: Gratitude Orientation (Modified for Grief)

"Standard gratitude exercises can feel offensive in grief. Here's a modified version: Instead of 'what are you grateful for?' ask: 'What is one small thing that didn't hurt today?' It might be the warmth of coffee. The sound of rain. A moment of not-thinking-about-it. This isn't toxic positivity. It's noticing that the window of tolerance still has space in it."

Why this works: Orienting toward neutral or mildly positive stimuli activates the ventral vagal system without requiring the griever to perform gratitude they don't feel. It builds the neural pathway for noticing 'not-pain' alongside pain \u2014 which is the neurological basis of oscillation in the Dual Process Model.

\ud83c\udfa7 Listen: [Jackson Browne \u2014 \"For a Dancer\"](https://youtu.be/XnT_PbnpijE) (YouTube, 6 min). Play this before journaling.

Keep a fire burning in your eye

Pay attention to the open sky

You never know what will be coming down

>

Into a dancer you have grown

From a seed somebody else has thrown

Go on ahead and throw some seeds of your own

Reflective Journaling Prompt: Continuing Bonds

"Take ten minutes. These questions are about meaning \u2014 not 'finding the silver lining,' but noticing what's already growing from what was planted."

1. What did the deceased person plant in the griever that is still growing? A value, a

phrase, a way of seeing the world?

2. Has the griever begun to \"throw some seeds of their own\" \u2014 passing something forward that came from the person they lost? What does that look like?
3. If you could name one way the deceased person's life still matters in the world today \u2014 not in memory, but in action \u2014 what would it be?
4. Is the griever ready for meaning-making, or are they still in the wanting? (Both are okay. Your job is to know which one you're looking at.)

> *"Browne wrote that song after a friend's death in 1974. Fifty years later it still teaches the same thing: the seeds don't stop growing when the gardener dies."*

\u27a1\ufe0f Next: Week 12 \u2014 The Long Game. Grief doesn't end at Week 12. We build a sustainable support plan for the months and years ahead.

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 12
The Long Game

Grief doesn't end at Week 12. Building sustainable, long-term support.

Session Objectives

- Accept that grief is lifelong (and that's not pathological)
- Build a sustainable long-term support plan
- Review what you've learned and how you've changed
- Prepare for the ongoing oscillation of grief over years

Supporter Checklist

[ ] Check-in: How is meaning-making emerging (or not)?
[ ] Discuss the long-term trajectory of grief
[ ] Build a sustainable support plan for the next 6-12 months
[ ] Review the full 12-week journey
[ ] Complete Worksheet: My Long-Term Support Plan

Session Script

"This is Week 12. It is not the end of grief. It is not the end of your role as supporter. It is the end of your structured education \u2014 and the beginning of applying what you've learned over the months and years ahead."

Grief Is Lifelong

"The grief will change. It will soften. It will become less consuming. But it will not disappear. The person you're supporting will carry this loss for the rest of their life. Five years from now, a song will play and they'll cry. Ten years from now, they'll reach for the phone to call the person who's gone. Twenty years from now, they'll wish the deceased could meet their grandchildren."

"This is not pathology. This is love. The grief is the love with nowhere to go. It doesn't expire. Writer J.S. Park described grief as a debt incurred 'to live and to love and to chase the stuff that gives us meaning' ~ we are, essentially, 'a life on loan.' The loan comes due. And the payment is grief. But the alternative ~ never loving deeply enough to grieve ~ is not a life worth protecting."

"Your job doesn't expire either. But it changes. In the acute phase (first year), your job was intensive: frequent contact, practical help, emotional holding. In the long-term phase, your job is lighter but consistent: remembering the dates, using the name, being the person who doesn't pretend it never happened."

What Changes Over Time

"Year 1: Acute grief. Frequent waves. High support needs. The griever is learning to live in a world that has fundamentally changed."

"Years 2-3: Integration. The waves are less frequent but can still be intense. The griever is rebuilding identity and routine. Support needs decrease but don't disappear."

"Years 3+: Carrying. The grief becomes part of who they are rather than something that's happening to them. They can talk about the deceased with both pain and warmth. They have a continuing bond that sustains rather than devastates."

"At every stage, what they need from you is the same: Don't forget. Don't pretend it didn't happen. Don't stop saying the name."

Your Long-Term Support Plan

"Sustainable support means: less intensive, more consistent. Here's what that looks like:"

"Monthly check-ins (minimum). A text, a call, a coffee. 'How are you doing with [name] stuff lately?' Not every conversation needs to be about grief. But the door stays open."

"Anniversary acknowledgment. Every year. 'I'm thinking about you and [name] today.' It takes 10 seconds. It means the world."

"Milestone inclusion. When something big happens in their life \u2014 a wedding, a graduation, a new baby \u2014 acknowledge the absence: 'I bet you wish [name] could see this.' They're already thinking it. You saying it tells them it's okay to feel both joy and grief simultaneously."

"Permission to not be okay. Even years later. 'You don't have to be over it. You don't have to perform healed. If it still hurts, it still hurts.'"

What You've Learned

"Over these 12 weeks, you've learned:"

"Grief is not a problem to solve. It's a process to accompany. The Dual Process Model shows us that oscillation between pain and functioning is healthy \u2014 not a sign of failure."

"Your nervous system matters as much as theirs. You cannot co-regulate from outside your own window. Your own regulation is the foundation of your support."

"There are three types of grief, and they require different responses. Normal grief needs presence. Complicated grief needs professional help. Traumatic grief needs trauma processing before grief processing can begin."

"Your role is witness, practical helper, and boundary-holder \u2014 not therapist, not savior, not grief police."

"Communication matters more than intention. What you say (and don't say) either opens space for grief or closes it. Use the name. Show up. Don't fix."

"You are also grieving. Your losses are real. Your compassion fatigue is real. You need support too."

"Grief doesn't end. Neither does love. Neither does your presence."

*"Joanne Cacciatore closes *Bearing the Unbearable* with this: 'Grief is not a disorder, a disease, or a sign of weakness. It is an emotional, physical, and spiritual necessity, the price you pay for love. The only cure for grief is to grieve.' Your job was never to cure their grief. Your job was to make the grieving bearable. And you did."*

> *What the Research Shows*
>
> *Bonanno's (2004) longitudinal research demonstrated that the most common grief trajectory is \"resilience\" \u2014 a brief period of acute distress followed by gradual return to baseline functioning. However, even resilient grievers report ongoing grief experiences (waves, anniversary reactions, continuing bonds) years after the loss. These are not signs of pathology but of enduring attachment. The key predictor of long-term adaptation is not the absence of grief but the presence of social support that acknowledges the ongoing nature of loss.*
>
> *Key Sources for This Week:*
> *- Cacciatore, J. (2017). Bearing the Unbearable. Wisdom Publications.*
> *- Bonanno, G. A. (2004). Loss, Trauma, and Human Resilience. American Psychologist, 59(1), 20\u201328.*
> *- Devine, M. (2017). It's OK That You're Not OK. Sounds True.*

Nervous System Regulation Exercise: Loving-Kindness (Metta) for the Griever and Yourself

"Close your eyes. Bring to mind the person you've been supporting. Silently say: 'May you find moments of peace. May your grief soften when it's ready. May you feel held even when I'm not there.'"

"Now bring yourself to mind. 'May I be gentle with myself. May I know that my presence matters. May I trust that I've done enough.'"

> *Why this works: Loving-kindness meditation activates the insula and anterior cingulate cortex \u2014 brain regions associated with empathy and self-compassion. Regular practice reduces compassion fatigue and increases the capacity to be present with others' suffering without absorbing it. It's a closing ritual that honors both the griever and the supporter.*

"This is not the end. This is the beginning of the long game. You now have the framework. Use it gently. Use it consistently. And remember: You don't have to be perfect. You just have to keep showing up."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

Appendix: Regulation Toolkit

21 evidence-based exercises for calming, grounding, activating, and self-soothing.

Calming Sympathetic Arousal

For fight/flight, activated, anxious states

- **Physiological Sigh** (1–3 breaths)
  Double-inhale through nose, long exhale through mouth. Fastest voluntary method for calming.
- **4-7-8 Breathing** (2–5 min)
  Inhale 4 counts, hold 7, exhale 8. Extended exhale stimulates vagus nerve.
- **Left Nostril Breathing** (5–10 min)
  Close right nostril with thumb, breathe only through left. Activates parasympathetic branch.
- **Humming / Vocal Toning**(3–5 min)
  Hum or produce a low 'voo' sound on exhale. Vibration stimulates vagus nerve through larynx.
- **Progressive Muscle Relaxation** (10–20 min)
  Tense each muscle group 5–7 sec, release. Feet to head. Interrupts tension-anxiety loop.
- **Hand on Heart** (1–5 min)
  Place hands over heart with gentle pressure. Releases oxytocin, reduces cortisol.

Activating from Shutdown

For numb, dissociated, foggy, dorsal vagal states

- **Cold Water / Temperature** (15–60 sec)
  Cold water on face triggers dive reflex — involuntary parasympathetic override.
- **Orienting** (2–5 min)
  Slowly look around the room with curiosity. Sends updated safety signals to brainstem.
- **Bilateral Movement** (2–3 min)
  March in place, right hand to left knee, left hand to right knee. Integrates hemispheres.
- **Gentle Shaking** (2–5 min)
  Stand, gently bounce from legs upward. Discharges stored survival energy (Levine).

Grounding Practices

For both activation and shutdown

- **5-4-3-2-1 Sensory** (3–5 min)
  Name 5 see, 4 touch, 3 hear, 2 smell, 1 taste. Anchors in present moment.
- **Weighted Contact** (10–20 min)
  Weighted blanket or firm pressure. Deep proprioceptive input signals safety.
- **Feet on Floor** (2–5 min)
  Press feet flat, imagine roots growing down. Gravity is constant and reliable.

Self-Soothing / Co-Regulation

Activate the social engagement system

- **Self-Havening** (2–5 min)

  Three touch areas: (1) Arm Havening — cross arms, stroke shoulder to elbow. (2) Face Havening — fingertips at center of forehead, sweep outward to temples; then fingertips beside nose, sweep outward across cheeks. (3) Palm Havening — rub palms together slowly. Activates C-tactile nerves, produces delta waves.

- **Butterfly Hug** (30 sec–2 min)

  Cross arms, alternate tapping shoulders. SHORT sets (10–30 sec) for calming.

Emergency / Crisis Tools

- Cold water on face — triggers dive reflex
- Physiological sigh — fastest voluntary calming
- Ice cube in hand — overrides dissociation
- Strong taste/smell — forces present-moment awareness
- Stamp feet hard — proprioceptive grounding
- Count backwards from 100 by 7s — engages prefrontal cortex

Match State to Practice

Panic / Acute Anxiety

Try: Cold water, Physiological sigh, 5-4-3-2-1

General Anxiety

Try: 4-7-8 Breathing, Hand on Heart, PMR

Dissociation / Numb

Try: Cold water, Orienting, Shaking, Strong smell

Shutdown / Collapsed

Try: Shaking, Bilateral Movement, Cold water

Hypervigilance

Try: Orienting, Humming, Left Nostril Breathing

Flashback

Try: 5-4-3-2-1, Feet on Floor, Orienting, Cold water

Anger / Discharge

Try: Shaking, Stamp feet, Bilateral Movement

Sleep Difficulty

Try: 4-7-8 Breathing, Self-Havening, PMR

Self-Compassion

Try: Hand on Heart, Self-Havening, Butterfly Hug

Based on polyvagal theory (Porges), Somatic Experiencing (Levine), and current neuroscience research.

Appendix: Your Digital Toolkit

This manual comes with a full set of online tools at curranscoachingmanuals.manus.space. Here is what is available to you.

- **12-Week Session Scripts**
  Complete scripts for every session. Read them out loud -- designed to sound like a real conversation, not a textbook.
- **Interactive Worksheets**
  Fillable in the app or printable. Completed worksheets save automatically so you can track patterns over time.
- **Regulation Toolkit (21 Exercises)**
  Organized by what your loved one is experiencing right now. Calming, grounding, activating, self-soothing, and emergency tools.
- **Binaural Beats Audio Environment**
  Bilateral stimulation tones through stereo headphones. Four presets, adjustable volume, ambient sounds. A relaxation aid, not therapy.
- **Guided Imagery Studio**
  Record guided imagery scripts in your own voice with BLS tones underneath. Teleprompter walks you through each section. Export as MP3.
- **Compassionate Inquiry Framework**
  Based on Gabor Mate's model. Reflective exercises woven into every weekly session to look underneath symptoms.
- **Coaching Journal**
  Private, searchable journal for tracking observations, patterns, and your own growth as a coach.
- **Progress Tracking**
  Visual indicators for module completion, worksheet status, and checklist items. Exportable for treatment team coordination.
- **Crisis Safety Plan**
  Structured plan with emergency contacts, warning signs, coping strategies. Fill it out before Week 1. Print two copies.
- **Self-Care Assessment**
  Honest assessment of your own well-being -- physical, emotional, social, spiritual. If you burn out, the program stalls.
- **Coach's Toolkit**
  Quick-reference tools, communication scripts, de-escalation strategies for in-the-moment use.
- **FAQ**
  The questions supporters actually ask: What if they refuse? What if I say the wrong thing? When do I call 911?
- **Downloadable PDF**
  This document. Print the whole thing or just the pages you need for a given session.

Access all tools at curranscoachingmanuals.manus.space

Appendix: Guided Imagery Scripts

From 101 Trauma-Informed Interventions by Linda Curran. Each script is available as an individual downloadable PDF and in the online Guided Imagery Studio with teleprompter and BLS audio.

The Container (Appendix 4)

Containment Imagery -- ~12 minutes

An imaginal resource for compartmentalizing distressing material in order to be present. Not repression -- a technique to attend to what needs attending to until the necessary resources are available.

Comfortable Place (Appendix 5)

Safe/Neutral Place Imagery -- ~15 minutes

Establishes a mental refuge -- a place of safety and calm the client can return to at any time. Uses all five senses to anchor the experience.

Repairenting (Appendix 6)

Imagery for Disrupted Attachment -- ~18 minutes

Addresses early attachment disruption by inviting the client to re-experience being cared for by a nurturing figure. Clinician-guided -- requires safety screening before use.

CLINICIAN-GUIDED: Requires safety consent before recording.

Care and Nurture (Appendix 7)

Imagery for Care and Nurture -- ~10 minutes

Develops the capacity to give and receive care. The client imagines nurturing a young being, then receiving that same quality of care.

Download individual script PDFs from the Guided Imagery Studio at curranscoachingmanuals.manus.space

Appendix: Suicide Screening

The Columbia Protocol (C-SSRS)

Asking about suicide does not plant the idea. It opens the door to honesty. The Columbia-Suicide Severity Rating Scale is the most widely used suicide screening tool in the world -- used by the military, the NFL, schools, and crisis centers in 140+ countries. The community version below is designed for non-clinicians. Use it during check-ins, after warning signs, or any time you are concerned.

1. "Have you wished you were dead or wished you could go to sleep and not wake up?"

This captures passive ideation -- the wish to not exist. It is common, it is important, and it is not the same as a plan.

2. "Have you actually had any thoughts of killing yourself?"

This is the critical pivot. If the answer is no, you can stop here and continue monitoring. If yes, continue to questions 3-6.

IF YES TO QUESTION 2 -- CONTINUE:

3. "Have you been thinking about how you might do this?"

This assesses whether ideation has moved to method. A person who has thought about a method is at higher risk than one who has not.

4. "Have you had these thoughts and had some intention of acting on them?"

Intent is different from ideation. Many people think about suicide without intending to act. This question separates the two.

5. "Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?"

A specific plan with intent is the highest-risk combination. If the answer is yes: this is an emergency. Call 988 or 911 immediately.

6. "Have you ever done anything, started to do anything, or prepared to do anything to end your life?"

Past behavior is the strongest predictor of future behavior. A history of attempts changes the risk calculation significantly.

What to Do Based on Answers

YES to Question 1 only:

Passive ideation. Increase monitoring. Mention it to the treatment provider at the next appointment. Do not ignore it -- but do not panic.

YES to Questions 2-4:

Active ideation. Contact the treatment provider today. Do not leave them alone. Remove access to means. Call 988 for guidance if unsure.

YES to Questions 5 or 6:

THIS IS AN EMERGENCY. Call 988 or 911. Remove all access to means immediately. Do not leave them alone.

Resources

- Columbia Protocol Community Cards: cssrs.columbia.edu (free, printable, available for families, spouses, parents, and teens)
- Columbia Protocol App: Free app that walks you through the questions in real time (available on iOS and Android)
- 988 Suicide & Crisis Lifeline: Call or text 988 (24/7, free, confidential)
- Crisis Text Line: Text HOME to 741741

Posner, K., Brown, G.K., Stanley, B., et al. (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. American Journal of Psychiatry, 168(12), 1266-1277.

Lethal Means Counseling

The Conversation That Saves Lives

Nine out of ten people who survive a suicide attempt do not go on to die by suicide. The crisis passes. But it only passes if they survive the attempt — and survival depends overwhelmingly on what method is available in the moment.

Reducing access to lethal means during high-risk periods is the single most effective thing you can do.

The evidence is unambiguous

- Means restriction reduces suicide rates by 30–50% at the population level (Barber & Miller, 2014, American Journal of Preventive Medicine).
- Firearms account for over 50% of all suicide deaths in the U.S. — and firearm attempts are fatal 85–90% of the time. Drug overdose attempts are fatal less than 3% of the time. The method matters.
- Most suicidal crises last minutes to hours, not days. If the most lethal means are not available during that window, the person is overwhelmingly likely to survive.
- Over 90% of attempt survivors do not go on to die by suicide (Owens et al., 2002; Harvard Means Matter project). The crisis is temporary. Death is not.

Firearms

This is the most important conversation and the hardest one. It is not about gun rights or gun control. It is about keeping someone alive during a temporary crisis. Frame it that way.

- Temporary off-site storage: Ask a trusted friend or family member to hold firearms temporarily — with a written agreement and a specific return date.
- Many gun shops and shooting ranges offer temporary storage. Call ahead.
- Some police departments accept voluntary temporary storage. Check your local department.
- If off-site storage is refused: Cable locks through the action ($10, adds critical delay). Store ammunition separately. A gun safe with a combination only you know.

Medications

- Medication lockbox: dispense daily amounts only. Keep the lockbox key with you.
- Return unused or expired medications to a pharmacy take-back program.
- Lithium, benzodiazepines, and opioids are high-lethality in overdose. Limit the supply available at any one time.
- For households with opioid access: keep Narcan (naloxone) on hand. Available over the counter at most pharmacies.
- Talk to the prescriber about prescribing smaller quantities during high-risk periods.

Other Means to Address

- Sharp objects: secure knives, razors, box cutters. Especially relevant for BPD and self-harm h
- Car keys: during acute crises, vehicle access can be a means. Hold the keys if the person is in a dissociative or impulsive state.
- Alcohol: intoxication dramatically increases impulsivity and lethality of attempts. Remove alcohol during high-risk periods.
- High places: if you live in a high-rise, window locks and balcony access matter during acute episodes.

How to Have This Conversation

Do it before a crisis, not during one. Frame it as temporary and collaborative, not punitive.

- *"I want to talk about something uncomfortable because I care about keeping you safe."*
- *"This is not about trust. This is about making sure you get through the hard moments."*
- *"Can we make a plan together for what to do with [specific items] during the rough patches?"*
- *"I read that most people who survive a crisis are glad they survived. I want to make sure you get that chance."*

Resources

- Harvard Means Matter: meansmatter.org — Research, data, and resources on means restriction
- Safer Homes Collaborative: saferhomescoalition.org — Firearm-specific safety planning for families

Barber, C.W. & Miller, M.J. (2014). Reducing a suicidal person's access to lethal means of suicide. American Journal of Preventive Medicine, 47(3), S264-S272.

Safety Plan Worksheet

Based on the Stanley-Brown Safety Planning Intervention

Complete this plan before a crisis — not during one. Fill it out together with your loved one during a calm moment. Keep copies in multiple locations.

Step 1: Warning Signs

What are the thoughts, moods, situations, or behaviors that tell me a crisis may be developing?

Step 2: Internal Coping Strategies

Things I can do on my own to take my mind off my problems without contacting another person:

Step 3: People and Social Settings That Provide Distraction

People I can contact or places I can go to help distract me:

Step 4: People I Can Ask for Help

People I can reach out to when I am in crisis:

Step 5: Professionals and Agencies to Contact

Therapist: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Local ER / Crisis Center: _____ Phone: _____
988 Suicide & Crisis Lifeline (call or text 988)
911 for immediate danger

Step 6: Making the Environment Safe

Steps I can take to remove or restrict access to lethal means (see Lethal Means Counseling appendix):

The one thing worth living for:

The single most important reason to stay alive — even when everything feels impossible:

Stanley, B. & Brown, G.K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256-264.

Important Disclaimer

This manual is an educational resource designed to support family members and friends. It does not replace professional treatment, including medication management, psychotherapy, or formal clinical intervention.

The Compassionate Inquiry exercises included in this manual are adapted from Gabor Mate's framework for use by lay supporters. They are not therapy. If any exercise brings up strong emotions or memories, please seek support from a qualified mental health professional.

If you or your loved one is in crisis, contact the 988 Suicide & Crisis Lifeline (call or text 988) or go to your nearest emergency room.

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