Grief and Bereavement Support: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Grief and Bereavement Support: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This guide accompanies the Grief and Bereavement Support programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 8. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this guide

This guide is for qualified practitioners who support clients through the Grief and Bereavement Support programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: grief as the reorganisation of a life around a loss, the tasks of mourning, the dual process model and the continuing bond, and how the eight modules are built
- Chapter 2, What the research shows: the course grief usually takes, how common prolonged grief is, the health effects of bereavement, what bereavement interventions achieve and for whom, and the treatments for grief that does not move

CHAPTER 1

The model behind the programme

What grief is

The programme begins from a position the practitioner should hold firmly: grief is not an illness and not a problem to be solved. It is the response of a whole person, in body, emotion, thought and behaviour, to the loss of someone whose presence shaped their life, and it is the price of having loved them. What the programme offers is not a cure for grief but company and structure in it: a way of understanding what is happening, a set of practices that make the weight easier to carry, and a clear account of when grief needs more help than a programme can give.

Two consequences follow for the contacts. The first is that the practitioner is not trying to make the grief smaller. A client who weeps through a contact is not getting worse, and a client who reports a terrible week after writing to their mother has very often done exactly the work the programme asks of them. The second is that the measures need reading with care. A PHQ-9 taken five months after a sudden death will often sit in the moderate range, because grief and depression share symptoms such as poor sleep, low energy, poor concentration and loss of interest. The score is followed up, as every score is, but the question the practitioner asks of it is whether the picture is grief, depression, or both, a question the fourth contact takes up in detail.

Tasks, not stages

Most clients arrive with the idea that grief moves through five stages: denial, anger, bargaining, depression and acceptance. The model was described by Kubler-Ross from interviews with people who were themselves dying, and it entered popular culture as an account of bereavement without ever having been established as one. When it was tested, in the Yale Bereavement Study, acceptance was the response bereaved people endorsed most often from the first month, and yearning, not disbelief or anger, was the dominant painful feeling throughout the first two years (Maciejewski et al., 2007). The negative feelings did tend to peak in roughly the order the model predicts, which the study's authors read as partial support, but nobody moved through them as stages. Stroebe, Schut and Boerner (2017) review the model's standing and conclude that it lacks sound evidence and practical use, and that the expectation that bereaved people will, or should, pass through stages can harm those who do not.

The programme uses instead the four tasks of mourning set out by Worden (2018): to accept the reality of the loss; to process the pain of grief; to adjust to a world without the person, externally, internally and spiritually; and to find an enduring connection with the person while embarking on the rest of life. The language of tasks matters clinically. A stage happens to a person; a task is something a person does, which restores some agency at a time when the bereaved feel they have none. And tasks are not done once and finished. The client returns to each of them, in any order, for years, so that a bad week at eight months is not a relapse to an earlier stage but another piece of work on a task that was always going to be revisited.

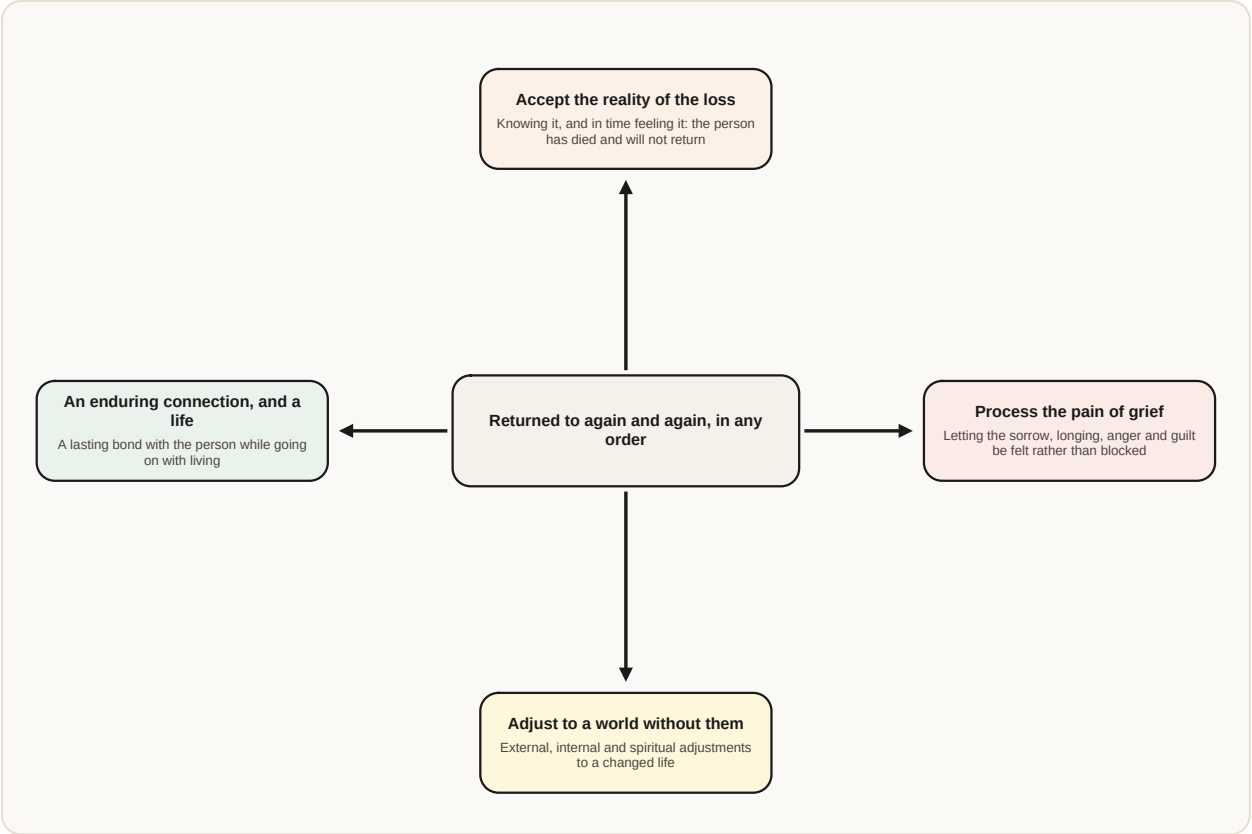


FIGURE 1.1 Worden's four tasks of mourning
The programme follows Worden in treating mourning as active work on four tasks rather than a passage through stages. The tasks overlap, are revisited for years, and are never simply completed; a client may be working on all four in the same week.

The dual process model

The second framework the programme uses throughout is the dual process model of coping with bereavement (Stroebe and Schut, 1999). Stroebe and Schut observed that people who grieve well do not work steadily through the loss until it is resolved. They oscillate between two orientations. In loss-orientation they face the loss itself: they remember, long for the person, weep, look at photographs, visit the grave. In restoration-orientation they attend to the life that remains: the practical tasks the death has left them, new roles and routines, and time off from grieving altogether, such as an ordinary day at work or an evening absorbed in a television programme. The movement between the two is the work. A client who spends a good afternoon with a friend and then feels guilty for having forgotten their grief for three hours has not betrayed the person who died; they have done what healthy grieving looks like.

The model gives the practitioner a simple and useful question for every contact: is this client moving between the two orientations, or are they stuck at one pole? A client who can do nothing but grieve, months after the death, and a client who has thrown themselves into work and practical arrangements and never allows the loss in, are both showing a pattern the programme can address, and both are patterns that, sustained, are associated with grief that does not move.

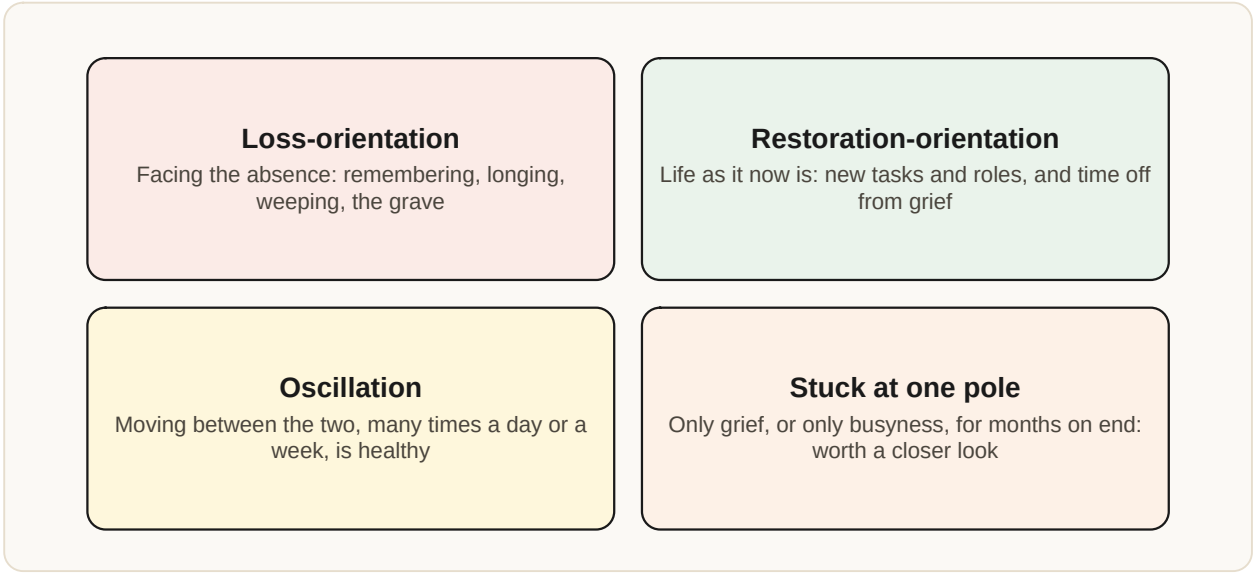


FIGURE 1.2 The dual process model of coping with bereavement
Stroebe and Schut describe healthy grieving as movement between facing the loss and attending to the life that remains. The movement itself is the work. A client who stays at either pole for months, all loss or all restoration, is the one to look at more closely.

The continuing bond

For most of the twentieth century the dominant clinical view, deriving from Freud, was that grief work meant gradually withdrawing emotional energy from the person who had died so that it could be invested elsewhere. The idea that healthy grief ends in letting go was challenged by Klass, Silverman and Nickman (1996), whose collection showed that bereaved children, parents and spouses commonly maintain an ongoing inner relationship with the person who has died, and that this is not in itself a sign of pathology. The programme takes their view: the goal is not to let go but to relocate the relationship, from one lived in the world to one carried inside, alongside a life

that continues. Module 5 is built on this, and Module 8 asks the client to plan how the bond will be tended over the years.

The practitioner should hold one distinction here, which Module 7 draws. A continuing bond carries the person into a life that is still being lived. Something different is happening when the bond is used to keep the death from being real: every belonging kept exactly in place for years, the person spoken of in the present tense, a life arranged around their absence. The difference lies less in the behaviour than in its function, and the question to ask is whether the bond is helping the client to live or helping them not to.

Meaning

Many bereaved people find that the death has disturbed not only their daily life but the assumptions by which they understood the world: that good people are safe, that the future can be planned, that their faith would hold. Neimeyer (2016) has described grieving as, in part, the reconstruction of meaning that the loss has challenged, and his research programme links the struggle to make sense of a loss with more intense and prolonged grief. The programme's third task includes these spiritual adjustments, and the practitioner's part is to make room for them without supplying answers. A practitioner does not tell a client why their mother died, or what God intends, or that everything happens for a reason; they ask what the death has done to the client's sense of how the world works, and they listen.

How the programme works

The programme follows the order in which most bereavement practitioners would work. Module 1 replaces the stages model with the tasks and the dual process model and asks the client to set out the loss and what they hope for. Module 2 maps the particular relationship and the secondary losses that come with the death. Module 3 turns to the body, because bereavement is a physical event as well as an emotional one. Module 4 widens the emotional picture beyond sadness, and draws the line between the numbness of grief and a depression that needs treatment. Module 5 works on the continuing bond, including a letter to the person who has died. Module 6 turns to rebuilding a life, practically, personally and socially. Module 7 is an honest look at grief that is not moving, at prolonged grief disorder and its risk factors, and at specialist help. Module 8 makes a plan for the anniversaries, the long quiet stretches and the years ahead.

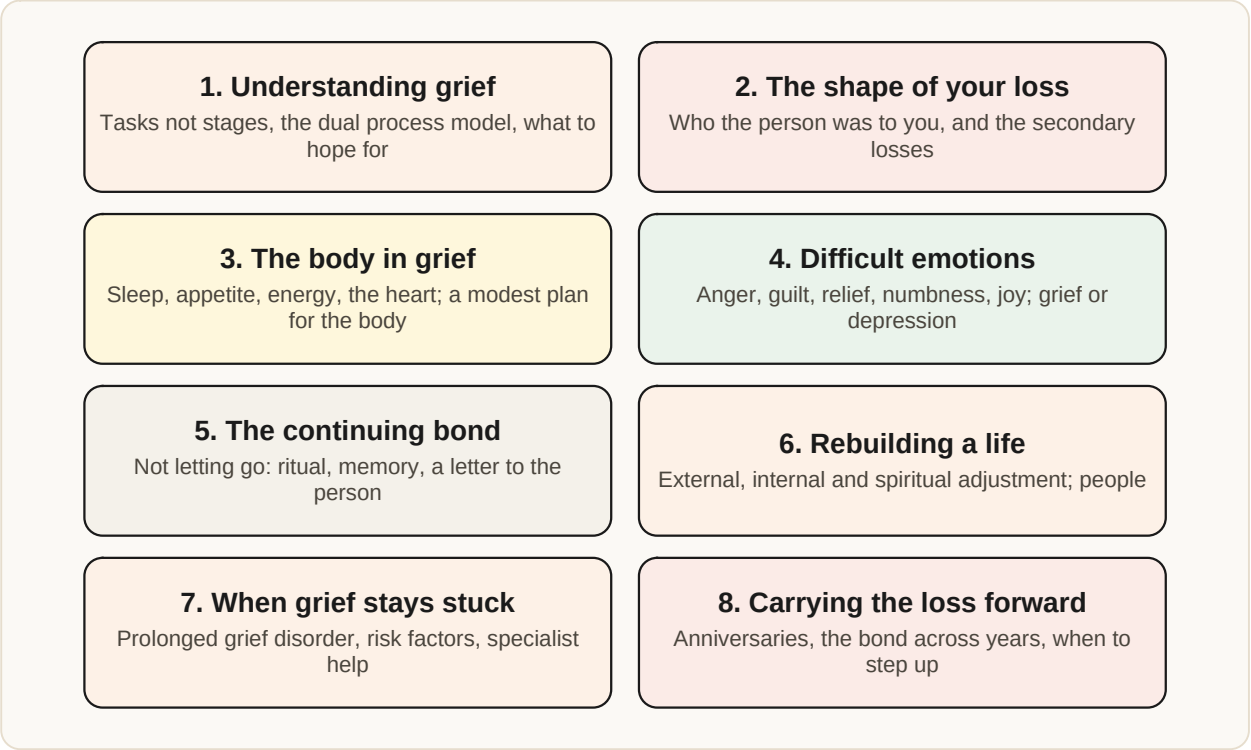


FIGURE 1.3 The eight modules and what each works on
The programme moves from understanding grief to the particular loss, the body and the emotions, then to the continuing bond and the rebuilding of a life, and ends with an honest look at grief that is stuck and a plan for the years ahead.

How the modules are built

Each module has an introduction, one to four teaching sections, worked examples that follow three people through their bereavements (Margaret, widowed after a forty-two-year marriage; Tomas, who cared for his mother through her last illness; and Rachel, whose younger brother was killed in a car accident), a sorting exercise that gives the client practice in recognising the module's ideas in other people's experiences, one to three worksheets, a closing summary and a reflection, "Taking this forward", which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. The programme takes four check-ins: the PHQ-9, the Work and Social Adjustment Scale and the CORE-10 in Module 1, and the PHQ-9, GAD-7, WSAS and CORE-10 in Modules 4 and 8. The CORE-10 is a ten-item measure of general psychological distress designed for routine use in the psychological therapies (Barkham et al., 2013), and it suits this programme well, because the distress of grief is caught only in part by measures of depression and anxiety. Take the GAD-7 at assessment too, since the programme first asks for it at Module 4.

A grief measure adds something none of these can. The PG-13-Revised is a thirteen-item scale built to match the criteria for prolonged grief disorder in the current revision of the American diagnostic manual, with a total symptom score of 30 or more as its threshold (Prigerson et al., 2021). The International Prolonged Grief Disorder Scale was the first self-report questionnaire built directly on the criteria in the World Health Organization's classification, and the first measure of disordered grief to set supplementary items, reflecting how grief is expressed in particular cultures, beside its core items; these were drawn from interviews with experts in grief and mental

health and a focus group of bereaved people, and feeling stuck in grief is one of them. Its preliminary validation, with 214 German-speaking and 325 Chinese bereaved adults, found strong internal consistency and good concurrent and criterion validity (Killikelly et al., 2020). Either can be taken at the start and end to follow the intensity of grief over the programme, provided the practitioner remembers that neither can indicate the disorder before its time criterion has passed, and that a score is a prompt for a conversation rather than a diagnosis.

The worked examples in this guide follow one composite client, Aisha, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner's part has three particular demands in grief. The first is steadiness. Bereaved people very often find that those around them cannot bear to hear about the death for long, change the subject, or offer comfort that closes the conversation down. The contact may be the one place each week where the client can speak about the person without managing someone else's discomfort, and the practitioner's tolerance of grief, unhurried and unalarmed, is part of what helps. The second is to follow the client's own relationship and culture rather than a script. Mourning customs, beliefs about death and what is owed to the dead differ widely, and within families as well as between them; the practitioner asks rather than assumes. The third is vigilance without pathologising. Most grief, however painful, is not a disorder, and the practitioner must not treat it as one; but a minority of bereaved people develop depression, prolonged grief disorder, post-traumatic stress or suicidal thinking, and the contacts are where these are noticed. Risk is asked about at every contact, as Chapter 10 describes, and with particular care after a death by suicide.

CHAPTER 2

What the research shows

Most bereaved people do not need professional help

The most important finding for anyone offering a grief programme is that most bereaved people come through without professional help. Bonanno and colleagues (2002) followed a large sample of older married people from before the death of a spouse to eighteen months afterwards. The commonest pattern, in 45.9 per cent, was resilience: low distress before the loss and throughout the bereavement. A further 10.7 per cent showed common grief, with distress that rose after the death and eased within the period; 15.6 per cent showed chronic grief, distress that rose and stayed high; 7.8 per cent were depressed before the loss and remained so; and 10.2 per cent had been depressed before the death and improved after it, often after long caregiving or a difficult marriage. The study's value lies in its pre-loss measurements, which allowed it to separate grief from depression that was already there.

A community survey in Australia tested the three-tier public health model of bereavement support, which predicts that about 60 per cent of bereaved people are at low risk and need only information and the support of those around them, about 30 per cent are at moderate risk and benefit from structured support such as groups or guided self-help, and about 10 per cent are at high risk and need specialist assessment and treatment (Aoun et al., 2015). The proportions found were close: 58.4, 35.2 and 6.4 per cent. This programme is designed for the middle tier. It is a structured support for people who are finding a loss heavy to carry, and it is not a treatment for prolonged grief disorder.

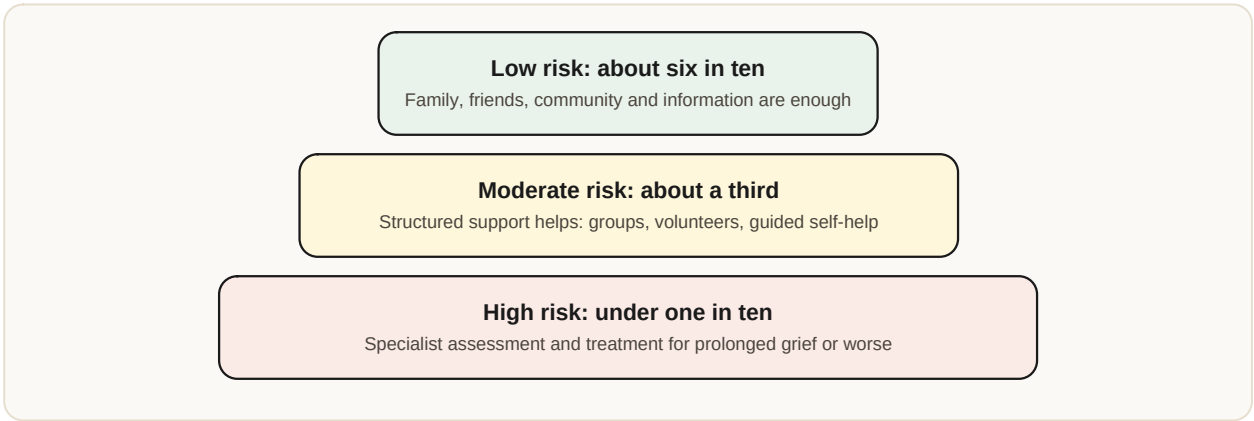


FIGURE 2.1 Who needs what after a bereavement
The public health model of bereavement support, tested in a community survey by Aoun and colleagues. Most bereaved people need information and the support of those around them; a substantial minority benefit from structured support such as this programme; a small group need specialist assessment and treatment.

Prolonged grief disorder

A minority of bereaved people develop grief that does not ease. Both of the main diagnostic systems now recognise this as prolonged grief disorder: the World Health Organization's classification, ICD-11, which requires the grief response to have persisted for at least six months

after the loss (World Health Organization, 2019), and the American Psychiatric Association's DSM-5-TR, which requires at least twelve months for adults (American Psychiatric Association, 2022). In both, the core of the disorder is persistent and pervasive longing for, or preoccupation with, the person who has died, accompanied by intense emotional pain such as sadness, guilt, anger, denial, difficulty accepting the death, a sense of having lost part of oneself, an inability to experience positive mood, emotional numbness, or difficulty engaging with life, lasting clearly longer than the person's social, cultural or religious context would expect, and causing significant impairment. These time frames are minimum periods before the disorder can be considered, not deadlines by which grief should be over, and the programme says so to clients explicitly.

A meta-analysis of fourteen studies of adults bereaved by natural causes found a pooled prevalence of prolonged grief disorder of 9.8 per cent, with higher rates in older samples (Lundorff et al., 2017). The rate is considerably higher after violent and sudden deaths. A systematic review of the effects of suicide bereavement found an increased risk of suicide among partners bereaved by suicide, increased risk of psychiatric admission among parents whose child had died by suicide, increased risk of suicide in mothers bereaved by an adult child's suicide, and increased risk of depression in children bereaved by a parent's suicide, together with more rejection and shame than after other deaths (Pitman et al., 2014). People bereaved by suicide are among those for whom the programme alone is unlikely to be enough, and for whom the risk questions matter most.

The health effects of bereavement

Bereavement affects physical as well as mental health. Stroebe, Schut and Stroebe (2007) reviewed the evidence that bereaved people have an increased risk of death, particularly in the early weeks and months, as well as more physical illness, more use of medical services and more days in hospital, with the excess falling unevenly by age, sex and the circumstances of the death. The most striking single finding concerns the heart. In a study of nearly two thousand people admitted to hospital with a heart attack, the risk of a heart attack was raised 21-fold in the twenty-four hours after the death of a significant person, and declined steadily on each following day (Mostofsky et al., 2012). The absolute risk remains small, but the finding is the reason Module 3 tells clients plainly that chest pain after a bereavement is not to be put down to grief, and the reason the practitioner never does so either.

What bereavement interventions achieve, and for whom

The evidence on bereavement interventions carries a warning that shapes how this programme should be offered. A meta-analysis of 61 controlled studies found that, taken together, interventions for bereaved people had a small effect at the end of treatment and no significant benefit at follow-up (Currier et al., 2008). The picture changed sharply when the interventions were sorted by whom they treated: interventions offered to all bereaved people, regardless of distress, did little, partly because people in the control groups improved naturally over time, whereas interventions for people showing marked difficulty in adapting to a loss had effects comparable to those of psychotherapy for other problems. A later meta-analysis of randomised trials reached the same conclusion more sharply: preventive interventions offered to bereaved people in general were not effective, while treatment for people with complicated grief reduced its symptoms, and the benefit grew during follow-up (Wittouck et al., 2011).

The practical meaning for the practitioner is twofold. The programme should be offered to people who are struggling, not to everyone who has been bereaved, and a client who is grieving painfully but well, moving between the orientations and functioning, may be best served by a single conversation, information and the reassurance that what they are experiencing is normal. And when grief is not moving, structured self-help is not the endpoint: treatments designed for prolonged grief exist and work.

Treatments for grief that does not move

Two treatments have the strongest evidence. Complicated grief treatment, developed by Shear and colleagues, combines elements of interpersonal therapy and cognitive behavioural therapy with exposure-based work on the story of the death and the avoided reminders, and with work on personal goals and the relationship with the person who has died. In a randomised trial of 95 people with complicated grief, sixteen sessions of complicated grief treatment produced a response in 51 per cent, against 28 per cent with interpersonal psychotherapy, and the response came faster (Shear et al., 2005). Shear (2015) summarises the clinical picture and its management for medical readers.

Cognitive behavioural therapy for complicated grief rests on a model in which grief is held in place by three processes: the loss not yet integrated into the person's knowledge of themselves and their life, negative global beliefs and catastrophic interpretations of their own grief reactions, and anxious and depressive avoidance (Boelen et al., 2006). In a trial with 54 bereaved people, cognitive behavioural treatment combining cognitive restructuring and exposure was more effective than supportive counselling; exposure on its own did more than cognitive restructuring on its own, and the sequence that began with exposure did best (Boelen et al., 2007). Related work shows why repetitive "why" and "if only" thinking keeps grief going: in a longitudinal study, the link between grief rumination and later complicated grief ran through experiential avoidance, suggesting that rumination works less as a confrontation with the loss than as a way of avoiding its most painful reality (Eisma et al., 2013). Module 7's account of what keeps grief stuck follows this model, and the practitioner's knowledge of these treatments is what allows them to describe specialist help to a client accurately and without alarm.

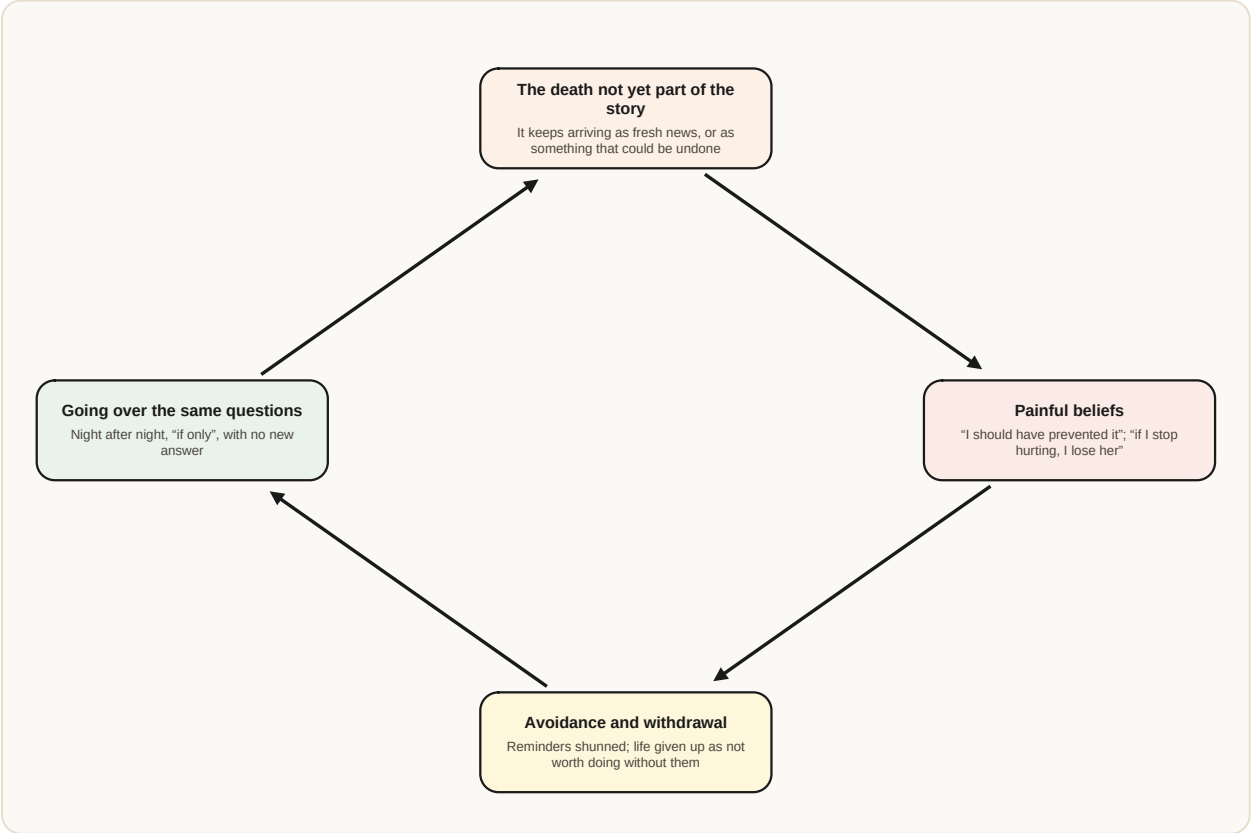


FIGURE 2.2 What tends to hold grief in place
Module 7's account, which follows the cognitive behavioural model of complicated grief. Each process is an understandable response to unbearable pain, and each brings relief in the short term, which is why it persists; together they keep the loss from becoming part of the person's story.

What this means for the programme

No trial has tested this programme in its present form. Its content applies the best-supported frameworks in the field, the tasks of mourning, the dual process model and the continuing bond, alongside psychoeducation about the body and the emotions of grief, behavioural planning, and the cognitive behavioural understanding of grief that does not move. It is suitable for guided self-help where a client is finding a bereavement heavy and wants structured support, and where neither prolonged grief disorder, a depressive episode of more than moderate severity, post-traumatic stress after a traumatic death, nor significant risk is the main picture. Where any of these is present, the programme can sit alongside specialist care but should not replace it.