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The GRIEF Model: A Recognition-Based Framework for Spiritual Assessment in Contexts of Ongoing Loss

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Abstract

Healthcare chaplains, alongside those serving in palliative, dementia-care, displacement, and correctional settings, increasingly accompany people whose losses occur while the person still lives—losses that progressively strip away autonomy, agency, identity, and coherent life narrative without offering the closure that bereavement following death affords. Standard spiritual assessment frameworks (FICA, HOPE, SPIRIT, and Spiritual AIM) were designed for broad clinical application rather than for grief as the organizing assessment principle in ongoing loss contexts, and they do not explicitly assess the oscillatory, anticipatory, and ambiguous dimensions that define such situations. This conceptual paper introduces the GRIEF Model, a five-domain spiritual assessment framework for ongoing loss intended for use with both patients and family caregivers. The model integrates five complementary sources: the DNA Model's dimensional content framework, the Dual Process Model's oscillatory coping mechanism, the construct of liminal competence, participatory sense-making, and a Lacanian account of structural unresolvability. The five domains—Grief Landscape, Resources and Resilience, Identity and Meaning, Existential Concerns, and Family and Connection—reorient assessment from identifying problems requiring resolution toward recognizing capacities patients already demonstrate, while surfacing where chaplaincy support might enable more sustainable threshold-dwelling. The paper details each domain's grounding, clinical application, and documentation priorities; translates domain findings into care planning; and specifies referral indicators distinguishing proportionate sustained grief from presentations requiring psychiatric evaluation. The GRIEF Model contributes to sociological and applied scholarship on chronic illness, biographical disruption, and the social organization of grief by offering a clinically operational alternative to resolution-paradigm assessment tools.

Subject Areas

Sociology

Keywords

Grief Assessment, Spiritual Care, Chaplaincy, Ongoing Loss, Liminal Competence, Biographical Disruption, Prolonged Grief Disorder

1. Introduction

1.1. The Problem of Ongoing Loss

Healthcare chaplaincy increasingly takes place at the intersection of two clinical realities that resist the assumptions embedded in conventional spiritual assessment tools. The first concerns the kinds of losses chaplains are asked to accompany. Progressive neurological disease, advanced cancer, palliative care, dementia caregiving, forced displacement, and incarceration all produce forms of grief that occur while the person continues to live—losses that strip away autonomy, agency, identity, and coherent life narrative in real time, without affording the temporal separation that grief following death provides [1]-[4]. The second concerns the persistent gap between what people in these situations describe and what existing frameworks are equipped to register. In most cases, they are not failing to adapt; they are accurately responding to circumstances in which adaptation toward stable resolution is foreclosed.

This paper uses the term structural unresolvability to name that condition in plain clinical terms: the loss has no endpoint at which grief could reasonably be expected to conclude, because the losses are ongoing, recurring, or lack any definable moment of closure. A patient with a degenerative illness does not grieve a single event and recover; each stage of decline brings fresh loss, so that grieving and losing occur simultaneously and continuously. It is important to stress that structural unresolvability names a common pattern in ongoing loss rather than an identical experience in every case. Patients and caregivers vary widely in how acutely they encounter it, how they interpret it, and what resources they bring to it; the framework that follows is an orienting lens, not a prediction about any individual.

The model is intended for use with both patients and family caregivers, since caregivers in progressive-illness and dementia contexts frequently carry anticipatory and ambiguous grief of their own [5] [6]. While the framework was developed primarily within healthcare chaplaincy, its domains are designed to be portable across the major ongoing loss contexts—chronic and progressive illness, displacement and migration [7], and incarceration [8]—with the recognition that the specific content of each domain will differ across these settings. Because grief is shaped by cultural and religious frameworks that vary in how they construe loss, dependence, and continuing bonds [9], some domains, and particularly the ques-

tions used to explore them, will need adaptation across different cultural and religious settings rather than uniform application.

1.2. Limitations of Existing Spiritual Assessment Frameworks

Several spiritual assessment frameworks are well established in clinical practice. FICA [10] structures a spiritual history around Faith, Importance, Community, and Address in care; HOPE [11] explores sources of Hope, Organized religion, Personal spirituality, and Effects on care; the SPIRITual history [12] surveys belief system, personal spirituality, integration with community, ritual practices, implications for care, and terminal-event planning; and Spiritual AIM [13] organizes care around three core needs—meaning and direction, self-worth and belonging, and reconciliation. These tools are valuable for mapping spiritual resources, beliefs, and practices, and broader frameworks for spiritual needs and chaplaincy practice support their use [14] [15]. The point here is not that they are deficient as general instruments but that they were designed for broad clinical application rather than for grief as the organizing assessment principle in ongoing loss.

Three concrete examples illustrate the dimensions of ongoing loss that these frameworks do not explicitly assess. First, none of the four tools assesses oscillation—the dynamic movement between confronting loss and engaging with ongoing life that the Dual Process Model identifies as the central mechanism of adaptive grieving [16] [17]. A spiritual history captures a relatively static snapshot of belief and practice; it does not register whether a patient can move flexibly between grief and restoration or has become fixed at one pole. Second, none distinguishes anticipatory or ambiguous loss—grief that has no death event to anchor it—from a discrete, retrospective spiritual history; yet for the patient mourning a future self or the caregiver mourning a person with dementia who remains physically present, the loss is a moving target rather than a settled fact [1]. Third, none provides a means of distinguishing proportionate sustained grief from grief that is being inadvertently pathologized as a failure to resolve, because these tools do not separate the multiple forms of hope at stake; the relinquishing of cure-hope can be misread as hopelessness rather than recognized as a distinct and proportionate grief. Where chaplaincy outcomes are measured, this matters: existing patient-reported outcome work demonstrates that chaplaincy effects can be captured empirically [18], but outcome measurement presupposes an assessment model adequate to the phenomenon, and for ongoing loss that model has been missing. The GRIEF Model is proposed to fill that gap by integrating the DNA Model's dimensional content framework [19] with the Dual Process Model's oscillatory mechanism [16] [17].

1.3. Scope, Aim, and Structure

This conceptual paper introduces the GRIEF Model as a five-domain spiritual assessment framework developed specifically for ongoing loss. The acronym organizes assessment around five dimensions that interact simultaneously: Grief Land-

scape, Resources and Resilience, Identity and Meaning, Existential Concerns, and Family and Connection. The model integrates the DNA Model [19], the Dual Process Model [16] [17], the construct of liminal competence drawn from the anthropology of liminality [20] [21], participatory sense-making from enactive cognitive science [22], and a Lacanian account of structural unresolvability [23]. Section 2 develops the theoretical background and explains why all five sources are needed together. Section 3 presents the five domains, each with grounding, clinical application, sample questions, and documentation focus, and closes by translating findings into care planning. Section 4 addresses conditions of use, referral indicators, and the empirical validation that remains necessary, before a brief conclusion situates the model within sociological scholarship on chronic illness and grief.

2. Theoretical Background

2.1. The Medical Grief Context

The phenomenology of medical grief differs substantially from bereavement following death. Patients must simultaneously navigate ongoing relationships with their losses while experiencing them in real time, lacking the temporal separation that post-death grief affords [1]. Anticipatory grief—mourning that begins before an impending loss occurs—is particularly complex because it requires grieving while maintaining a relationship with the dying person or with one's own declining body, generating paradoxical demands: preparing for separation while remaining present, and letting go while holding on [5] [6]. Unlike post-death bereavement, it lacks clear temporal boundaries, typically beginning at diagnosis and continuing across the illness trajectory [24].

Serious illness systematically strips away autonomy—the capacity for self-governance fundamental to adult identity [3]. Progressive disease creates cascading autonomy losses, from yielding control to medical systems at diagnosis to total care dependence at end stage, and cultural contexts significantly shape how this is experienced [9]. Closely related but distinct, agency—the capacity to act meaningfully in the world and shape one's narrative—is assaulted through physical limitation, treatment burden, and the foreclosure of valued life projects, threatening fundamental needs for efficacy and extending grief to encompass the future selves that disease has made impossible [25] [26]. Biographical disruption describes how chronic illness shatters taken-for-granted assumptions about identity and trajectory across explanatory, resource-mobilizing, and biographical dimensions [27]. The result is a condition of permanent liminality: illness prevents return to a pre-illness self while progression prevents consolidation of any stable post-illness self, so that patients dwell at the threshold rather than passing through it [28]. This is not a failure of adaptation but an accurate structural description of ongoing loss.

2.2. The Dual Process Model and Oscillatory Coping

The Dual Process Model describes the movement between loss-oriented coping—confronting grief and engaging the reality of loss—and restoration-oriented cop-

ing—attending to life changes and taking respite from grief [16]. It challenges linear stage models by emphasizing that healthy grief involves flexible oscillation rather than unidirectional progression toward resolution. For ongoing loss, the critical adaptation is the recognition that oscillation does not diminish toward resolution over time but continues as a sustainable regulatory pattern for managing persistent losses [17]. Assessment, therefore, focuses on oscillation flexibility—the capacity to shift between orientations—rather than on progression toward decreased grief intensity. The Dual Process Model describes oscillation mechanics but offers limited guidance on grief's content dimensions, while the DNA Model maps content comprehensively but gives less explicit attention to oscillation dynamics [19]; together they enable assessment that is both mechanistically and dimensionally adequate.

2.3. The Recognition Paradigm

The GRIEF Model operationalizes what may be termed a recognition paradigm for ongoing loss. This paradigm reorients assessment from resolution to acknowledgment, from closure to sustained dwelling, and from grief-as-pathology to grief-as-relational-practice. It does not replace resolution-oriented approaches for episodic bereavement but provides an alternative for contexts where resolution is structurally unavailable or clinically inappropriate. Its commitments are fivefold: it validates sustained grief as a proportionate response rather than a pathological complication; it emphasizes threshold-dwelling competence rather than progression toward resolution; it supports flexible oscillation as a sustainable pattern rather than a transitional phase; it legitimizes chaplaincy presence that accompanies rather than intervenes toward predetermined outcomes; and it distinguishes appropriate sustained grief from presentations requiring clinical treatment through oscillation and competence assessment rather than through temporal metrics that pathologize persistence as such [29]. These commitments do not constitute a refusal of clinical rigor; the paradigm actively distinguishes proportionate grief from presentations requiring psychiatric assessment, a distinction operationalized in Section 4.

2.4. An Integrated Framework: Why All Five Sources Are Needed

The GRIEF Model reads as an integrated framework rather than a layered list of influences because each source contributes something the others cannot supply. The DNA Model provides the content of assessment—the three simultaneous dimensions of connection, loss, and life continues that specify what grief actually encompasses [19]. The Dual Process Model provides the process—the oscillatory mechanism that specifies how grief operates moment to moment and over time [16] [17]. Liminal competence provides the developmental target—the specific capacities (ambiguity tolerance, oscillation flexibility, communitas access, and liminal meaning-making) that constitute skillful dwelling at a threshold one cannot cross, rather than a generic notion of coping [20] [21]. Participatory sensemaking provides the relational epistemology—the recognition that assessment is

not the extraction of information from a patient but a meaning that chaplain and patient construct together in their embodied encounter, which is why the same questions yield different findings in different relationships [22]. Finally, the Lacanian account provides the structural rationale—an explanation of why certain losses cannot be resolved through meaning-making at all, because they involve a confrontation with what exceeds symbolization, and therefore why a resolution paradigm misdiagnoses the situation from the outset [23]. Content without process yields a static inventory; process without a developmental target yields movement with no criterion of skill; both without a relational epistemology yield an extraction model that misunderstands the encounter; and all of these without the structural account risk treating an unresolvable situation as a failed resolution. The five are needed together because each closes a gap the others leave open.

3. The GRIEF Model: Five Assessment Domains

The GRIEF Model structures spiritual assessment around five domains reflecting essential dimensions of grief in ongoing loss. The acronym provides mnemonic utility while structuring assessment comprehensively, progressing from grief mapping through existing strengths, identity reconstruction, existential questioning, and relational dimensions. These domains interact simultaneously and dynamically, mirroring the DNA Model's insistence that grief dimensions cannot be artificially separated [19]. The domains are explored progressively across an extended chaplaincy relationship rather than completed in a single encounter.

3.1. Domain G: Grief Landscape

Primary Grounding: The DNA Model [19]; the Dual Process Model [16] [17]; disenfranchised grief [4]; and ambiguous loss [1] [2].

The Grief Landscape domain provides comprehensive mapping of the patient's grief terrain, assessing all three DNA dimensions—connection, loss, and life continues—simultaneously across multiple loss categories [19]. Loss of physical mobility, for example, simultaneously affects connection to the identity of independence, generates separation pain requiring emotional processing, and necessitates practical adaptation as life continues with reduced function. The chaplain tracks whether the patient can move between confronting what is absent and engaging what remains with reasonable flexibility, or is fixed at one pole [17].

The chaplain assesses losses across several content categories: physical losses carrying identity significance beyond practical inconvenience [25]; psychosocial losses of independence, role, privacy, and dignity [26]; anticipatory losses involving mourning while remaining present [6]; current grief unfolding in real time; and compounded historical grief, where present losses reactivate earlier experiences and create layered grief that may appear disproportionate to current stressors alone. Drawing on the disenfranchised grief taxonomy [4], the chaplain attends to losses the patient cannot openly acknowledge or have socially supported, and the ambiguous loss framework [1] [2] sensitizes the chaplain to losses without

a clear endpoint—the gradual psychological absence of a person with dementia, or the loss of a future self not yet fully mournable. These disenfranchised and ambiguous dimensions are frequently the most significant and the most underaddressed in standard spiritual care.

Sample Assessment Questions:

- How was this specific loss connected to who you were before?
- What does it mean for your sense of self to no longer fulfill this role or capacity?
- Can the pain of this loss be held alongside other experiences, or does it feel overwhelming?
- Are there losses you feel you are not permitted to grieve, or that others do not recognize?

Documentation Focus: Loss categories and their symbolic weight; which DNA dimensions the patient accesses readily versus those that prove difficult; oscillation pattern between loss and life-continues dimensions; temporal complexity (anticipatory, current, compounded, historical); and disenfranchised or ambiguous losses lacking social recognition.

3.2. Domain R: Resources and Resilience

Primary Grounding: The Dual Process Model [17]; liminal competence [20] [21]; salutogenesis [30]; and meaning-making capacity [31] [32].

This domain is the model's most direct operationalization of liminal competence, comprising four capacities for sustainable dwelling at permanent thresholds. Ambiguity tolerance—the capacity to live with paradox without forcing premature resolution—is assessed by how the patient responds to the irresolvable contradictions ongoing loss generates [21]. Oscillation flexibility—the capacity to move intentionally between loss-oriented and restoration-oriented coping without fixation—is the primary behavioral indicator from the Dual Process Model [17]; loss-oriented fixation manifests as continuous grief without respite, while restoration-oriented fixation manifests as compulsive busyness and brittle positivity. Communitas access—the capacity to connect with fellow threshold-dwellers in relationships of genuine mutual recognition, distinct from relationships of care or oversight—is assessed by whether the patient has access to such bonds, including peer support and chaplaincy relationships structured on a companion model [20] [33]. Liminal meaning-making—the capacity to generate significance in the act of dwelling itself—is assessed by what forms of meaning the patient is finding within the threshold; the empirically supported distinction between sense-making and benefit-finding is useful here, with neither track superior to the other [31].

Beyond these four capacities, the chaplain assesses broader resilience resources: sense of coherence as an overall orientation to stressors [30]; spiritual resources, distinguishing adaptive spiritual coping from maladaptive patterns of divine punishment or abandonment; and cultural narratives, which may sustain identity or impose unrealistic expectations of resolution [9] [19].

Sample Assessment Questions:

- How do you move between focusing on your losses and engaging with current life?
- Can you hold contradictory feelings at once—for example, wanting to fight and wanting to let go?
- Do you know anyone who truly understands what this is like from the inside?
- Have you found any meaning in how you are navigating this, even if the loss itself makes no sense?

Documentation Focus: Current levels of each liminal competence dimension; oscillation pattern (healthy flexibility, loss- or restoration-oriented fixation, or pervasive stuckness); adaptive versus maladaptive spiritual coping; sense of coherence; and cultural contexts shaping available resources.

3.3. Domain I: Identity and Meaning

Primary Grounding: Biographical disruption [27]; loss of self [25] [26]; meaning reconstruction [32] [34] [35]; narrative medicine [36]; and continuing bonds [37].

This domain addresses the biographical rupture that serious illness creates. The concept of loss of self provides the foundational account: illness strips away not merely what one does but who one is, as access to roles and social positions erodes without the simultaneous development of equally valued replacements—a progressively diminished self-concept that the resolution paradigm can only register as failure to reconstruct, and that the recognition paradigm understands as an accurate structural consequence [25]. Biographical disruption operates across explanatory, resource-mobilizing, and biographical dimensions, and assessment attends to which is most pressing for this patient now [27].

Three narrative structures organize how seriously ill persons relate their experience: the restitution narrative (illness leads back to health), the chaos narrative (illness unmakes coherent experience), and the quest narrative (illness becomes a journey toward meaning) [36]. For ongoing loss, the restitution narrative is structurally unavailable, and the chaplain assesses whether the patient is stuck in a failed restitution narrative, inhabiting chaos, or moving toward a quest. Meaning-making assessment draws on the distinction between sense-making and benefit-finding [31], recognizing that the adjustment value of meaning-making depends on whether the process produces an actual meaning made; absent that product, the search alone does not necessarily improve adjustment [32]. The clinical implication is precise: a search for meaning that produces no meaning does not improve adjustment, so chaplaincy that facilitates the search without attending to whether meaning is found may sustain rather than relieve distress. The absence of explicit meaning-making is itself a legitimate finding, since some patients never construct meaning from their losses, and this can be a fully adequate adaptation [38]. The same interpretive principle governs continuing bonds: the priority is the patient's subjective experience of the bond and what its expression means to them, rather than an inventory of its frequency or form [35] [37].

Sample Assessment Questions:

- How has illness affected your sense of who you are? What remains of who you were?
- How would you tell the story of this illness—does it have a shape, or does it feel formless?
- Have you found any meaning in how you are navigating this, even if the suffering makes no sense?

Documentation Focus: Identity disruption severity and degree of continuity or rupture; which dimension of biographical disruption is most pressing; current narrative structure (restitution, chaos, quest); meaning-making attempts, including searching, discovered meaning, or accepted meaninglessness; and identity reconstruction efforts and support needs.

3.4. Domain E: Existential Concerns

Primary Grounding: Existential psychology [39] [40]; meaning-making theory [32]; theological hope [41] [42]; and Lacanian structural unresolvability [23].

This domain addresses the ultimate meaning questions serious illness raises, focusing on the life-continues dimension of the DNA Model. Death, meaninglessness, isolation, and freedom are ontological conditions—facts of human existence that suffering brings into acute focus [40]. The chaplain's posture is explicitly non-resolution-oriented: the task is not to address these concerns but to witness them, validate their seriousness, and identify what resources the patient draws on to dwell with what cannot be answered [23]. Hope requires multi-dimensional assessment: cure-hope is often the first form foreclosed by illness, and its loss requires grief in its own right, while comfort-hope, connection-hope, transcendent hope, and generalized hope may persist. Theological resources articulating hope grounded in faithfulness to the present rather than in outcomes are particularly relevant for patients whose cure-oriented hope has been exhausted, who need permission to inhabit a different form of hope rather than being assessed as hopeless [41] [42].

Theological assessment explores theodicy struggles, shifts in the divine relationship, and forgiveness themes, and attends to afterlife beliefs, which do not always provide comfort: some patients hold beliefs that render a continuing bond frightening, including the prospect that a loved one is being punished [37]. A critical caution governs forgiveness specifically: chaplains must never pressure forgiveness in any form, since some situations cannot and should not be forgiven on a human timeline, and assessment must respect the patient's own discernment. The chaplain's role throughout is to hold the questions, not to determine their answers [39].

Sample Assessment Questions:

- What worries you most about death itself—not only what will be lost, but what death means?
- Where do you feel God is—or is not—in this situation?
- What do you hope for now? What form does hope take for you?
- Are there things, with others or with God, that feel unfinished or unresolved?

Documentation Focus: The existential concerns most pressing for this patient and their intensity; forms of hope present, absent, or in transformation; theological struggles and resources; forgiveness themes requiring gentle support; and language-failure moments signaling contact with content that exceeds the patient's symbolic resources and requires witness rather than interpretation.

3.5. Domain F: Family and Connection

Primary Grounding: Continuing bonds [43]; attachment theory [44]-[46]; ambiguous loss [1]; communitas [20]; and participatory sense-making [22].

This domain evaluates the DNA Model's connection dimension directly, examining attachment patterns, relational strain, and unfinished relational business [43] [44] [46]. Continuing bonds theory provides the orientation: the goal of grief in ongoing loss is not the severing of bonds but their transformation and sustained maintenance in forms appropriate to the changing reality [43]. This transformation has been described as relocation—a partial loosening of the bond accompanied by its continuation [46]—and the chaplain assesses not whether bonds persist but what form they are taking, and whether continuing bonds are embedded in relational and cultural fields that sustain or silence them [37] [47].

Attachment patterns are retained here as a deliberately limited assessment lens rather than an explanatory theory of grief: they map how patients seek and use relational support and what accompaniment will be most supportive [45]. Three clinically distinct patterns carry direct implications: the secure style seeks and uses support adaptively; the anxious style seeks constant reassurance and experiences separation as catastrophic; and the avoidant style presents as self-sufficient in ways that may mask profound relational need [48]. The ambiguous loss framework is especially relevant for dementia caregiving, where the caregiver who is simultaneously mourning and caring for the same person faces frozen grief that cannot be concluded because the loss cannot be confirmed [1]. Finally, participatory sense-making reminds the chaplain that the chaplaincy relationship is itself a relational resource: the quality of embodied co-presence the chaplain brings models the accompaniment that enables threshold-dwelling [22].

Sample Assessment Questions:

- How are the people closest to you handling this illness?
- What do you most want the people you love to know or remember?
- Is there anything in your relationships that feels unfinished or unsaid?

Documentation Focus: Family system strengths and vulnerabilities; attachment patterns shaping support-seeking; communication patterns facilitating or impeding shared grief; ambiguous loss dynamics and degree of frozen grief; communitas access; legacy concerns; and relational needs requiring referral.

3.6. From Assessment to Care Planning

Because assessment is meaningful only insofar as it changes care, each domain points toward specific chaplaincy responses, follow-up, and interdisciplinary re-

ferral. In the Grief Landscape, disenfranchised and ambiguous losses call first for naming and validation, while compounded historical grief that reactivates earlier trauma may warrant referral to bereavement counseling or mental health services [4]. In Resources and Resilience, oscillation fixation indicates targeted accompaniment that gently invites movement toward the neglected pole; absent communitas indicates connecting the patient to peer support or a sustained chaplaincy relationship [33]; and maladaptive spiritual coping indicates ongoing spiritual care focused on the patient's relationship with their tradition. In Identity and Meaning, a chaos narrative calls for witness without forcing premature coherence, a failed restitution narrative calls for grief support around relinquishing the recovery arc, and a meaning-search producing distress calls for a shift from stimulating the search to simply accompanying the patient wherever it leads [32]. In Existential Concerns, theodicy distress and punitive afterlife beliefs call for unhurried theological accompaniment, forgiveness themes call for gentle support that never pressures, and language-failure moments call for witness rather than interpretation [37]. In Family and Connection, findings translate into attachment-informed presence tailored to the patient's pattern, caregiver support, and possible referral where frozen grief is present, focused relational work around unfinished business, and referral to social work or family therapy where systemic strain exceeds the chaplain's scope [48]. Across all five, assessment is iterative rather than single-session, and documentation feeds the interdisciplinary team so that spiritual findings inform the broader plan of care [18] [49].

4. Implementation Considerations and Limitations

4.1. Conditions of Use

The GRIEF Model is designed for use within extended chaplaincy relationships rather than single-visit encounters; comprehensive assessment across all five domains may require several encounters distributed across weeks or months. It functions as an orienting framework that keeps the chaplain attentive to the full range of grief dimensions, not as a protocol requiring completion. Implementation requires specific formation capacities—sustained contemplative practice, theological humility, and a relational orientation that positions the chaplain as a fellow threshold-dweller rather than an expert diagnostician [33]. The capacity to remain present at the limit of what can be known or said is not a supplement to using this tool but its precondition; a chaplain who experiences the most demanding assessments as tasks requiring answers, rather than as invitations to remain present with what cannot be answered, will misuse the framework.

4.2. Referral Indicators: Distinguishing Sustained Grief from Disorder

The recognition paradigm validates sustained grief, but validation must not obscure presentations that require psychiatric evaluation. Because the model is designed for situations in which loss is ongoing, duration of grief is explicitly not a

red flag: a grief that persists is proportionate when the loss itself persists, and the diagnostic criteria for prolonged grief disorder were developed for bereavement following death rather than for ongoing loss [50] [51]. The discriminating indicators are therefore not how long grief lasts but whether functioning, safety, and the capacity to oscillate have collapsed. Chaplains should facilitate prompt referral when any of the following are present:

- Persistent suicidal ideation, intent, or planning, or any acute concern for the patient's safety, warrants immediate referral and not deferral to a later visit.
- Active psychosis, severe disorganization, or marked confusion not attributable to the underlying medical condition.
- Severe functional incapacitation beyond what the illness itself explains—an inability to perform basic self-care or to engage at all with daily life that does not remit even briefly.
- Complete collapse of oscillation: continuous, unremitting grief with no accessible respite over an extended period, or, conversely, a total foreclosure of grief that the patient cannot interrupt.
- Symptoms consistent with a major depressive episode that are distinguishable from grief—pervasive worthlessness, anhedonia unrelated to the loss, and psychomotor change—rather than the wave-like sorrow of grieving.

These indicators draw on established clinical work distinguishing grief from depression and from disordered grief [52] [53], and on the prolonged grief disorder criteria now codified in diagnostic systems [50] [51] [54]. At the same time, the inclusion of grief disorders in diagnostic manuals remains contested, and chaplains should hold these categories with appropriate caution so as neither to over-pathologize proportionate grief nor to miss a treatable disorder [29] [55] [56]. The chaplain's task is not to diagnose but to recognize when the threshold between proportionate sustained grief and clinical disorder may have been crossed, and to ensure the patient reaches the appropriate professional.

4.3. Limitations and Future Research

The GRIEF Model is presented as a pedagogical and clinical-reflection framework rather than a validated psychometric instrument; its reliability, validity, and clinical utility have not been established and require empirical investigation before claims of effectiveness can be advanced [49] [57]. The model is designed for ongoing and chronic loss and is not intended for acute or episodic bereavement, where resolution-oriented approaches remain appropriate. It does not replace psychiatric assessment, and the referral indicators above are integral rather than supplementary to its safe use. Its present value lies in demonstrating that the recognition paradigm's commitments can support rigorous assessment—validating ongoing grief, honoring threshold-dwelling, and supporting sustainable oscillation—without pathologizing proportionate responses to genuinely unresolvable situations. Future research should pursue psychometric development, outcomes investigation, building on existing chaplaincy measures [18], and cross-cultural

validation across the illness, displacement, and incarceration contexts the model is intended to serve.

5. Conclusions

This paper has introduced the GRIEF Model as a recognition-paradigm spiritual assessment framework for ongoing loss. By integrating the Dual Process Model's oscillatory coping, the DNA Model's dimensional content, the construct of liminal competence, participatory sense-making, and a Lacanian account of structural unresolvability, the model offers chaplains a clinically operational alternative to assessment tools that presuppose a resolution trajectory unavailable to patients and caregivers in ongoing loss. Its five domains structure assessment around dimensions that interact simultaneously, map not only what is being lost but the capacities patients already demonstrate for sustained threshold-dwelling, and translate findings into care planning and appropriate referral.

The model contributes to sociological and applied scholarship on chronic illness, biographical disruption, and the social organization of grief. It extends the account of biographical disruption into the assessment encounter [27], draws the anthropology of liminality into clinical use by treating threshold-dwelling as a sustainable location requiring its own competencies [20], and engages the sociology of meaning-making by recognizing that meaning-attempts producing no meaning do not necessarily improve adjustment and that the absence of meaning-making may itself be an adequate adaptation [32] [35]. Empirical validation remains necessary before clinical effectiveness can be claimed; the recognition paradigm it operationalizes, however, is already indicated by what people in ongoing loss consistently teach—that to continue grieving is to continue loving, and that faithful presence at a threshold which admits no crossing is not a failure of care but precisely the care that structural unresolvability requires.

Conflicts of Interest

The author declares no conflicts of interest.

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