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The DNA Model of Grief: An English-Language Exposition of a Non-Teleological Framework for Ongoing Loss

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Abstract

The DNA Model of grief by Verthriest & Maes in 2017, a Dutch-language framework almost unknown in English, denies grief an endpoint as a stated first principle: mourning has a beginning but no end for as long as the bereaved person lives. This article provides the first sustained English-language exposition of the model. It first distinguishes bereavement after a death from ongoing loss before death—progressive illness, dementia caregiving, lifelong disability—and defends extending the model, stated for the bereaved, to loss that is still occurring. It expounds the model's three simultaneously active dimensions (connection, loss, and life continues) and its four guiding principles, and specifies precisely what kind of endpoint is denied: a normative terminal state of completed grief, as distinct from the reduction of acute grief and the recovery of functioning, which the model does not dispute. Because a non-resolution account risks legitimizing permanent suffering, the article derives from the model's own structure a distinction between healthy endpoint-less grief and pathological grief, locating the boundary in dimensional configuration rather than duration and relating it to prolonged grief disorder. Implications for chaplaincy assessment, documentation, and pastoral posture follow. Claims about the English-language literature are limited to the frameworks examined, and the model's single-source, non-validated basis is stated without mitigation.

Subject Areas

Pedagogy

Keywords

DNA Model of Grief, Ongoing Loss, Nonfinite Loss, Chaplaincy, Spiritual Care, Prolonged Grief Disorder, Endpoint Assumption

1. Introduction

A chaplain leaves the room of a woman whose husband has advanced Huntington's disease. She has been at his bedside most days for three years, and he no longer recognizes her reliably. In the electronic record, the chaplain writes a sentence that the attending physician, the nurse, and the social worker will read: "Patient's wife continues to struggle with acceptance."

The sentence is unremarkable, and it is a theoretical claim. The word *continues* installs a clock against which the wife's grief is measured and found late; the word *acceptance* installs a destination she has failed to reach. Neither word was chosen by the chaplain in any deliberate sense. Both were supplied by a model of grief that entered clinical language a half-century ago and has not left it.

A terminological boundary must be drawn at the outset, because it governs everything that follows. English-language grief theory developed largely around *bereavement*—the response to a death that has already occurred, a loss that is complete and located in the past. The situations this article concerns are different in kind: they are *ongoing* or *living* losses, in which the loss is still occurring and no death has yet taken place—the progressive erosion of a spouse in dementia, the accumulating deficits of a degenerative illness, the altered permanent future announced by a child's lifelong disability. Such losses have been theorized as nonfinite loss [1], living loss [2], and ambiguous loss [3]. The distinction matters here for a specific reason. The model this article introduces [4] states its central principle in terms of *the bereaved person*, the survivor of a death; applying that principle to loss before death is a move its authors do not make, and one this article therefore treats as an extension requiring justification rather than an equivalence to be assumed. The justification is given in §7. For now it is enough to mark that the extension is deliberate, and that the two situations, while structurally related, are not identical.

For the ongoing losses just named, the endpoint presumption is not merely inaccurate but, this article will argue, potentially harmful. Where no stable post-loss state is available, a model that treats one as normative will tend to read the griever as failing. The concern is conceptual rather than empirically established: the claim is not that endpoint-oriented language has been shown to worsen outcomes or to alter what a care team believes, but that it introduces a normative standard the situation cannot meet, and that documentation written to that standard may carry the resulting judgment into a shared record that clinicians have little occasion to interrogate. Whether such language measurably shapes team behavior or patient self-understanding is an empirical question this article does not settle; the argument here concerns the coherence of the standard, not its demonstrated effects.

A grief framework built on the opposite premise already exists. The DNA Model of Verthriest and Maes [4], published in Dutch as *Het DNA van rouw*, holds as a stated first principle that mourning has a beginning but no end for as long as the bereaved person lives. This is not the weaker and more familiar claim that grief *may* persist, or that persistent grief is *permissible*; it is the claim that

grief has no endpoint as a property of what grief is. The model is almost unknown outside the Low Countries: no English translation exists, and it has received no sustained treatment in English-language scholarship, having been cited only in passing [5].

This article provides that treatment. It distinguishes bereavement from ongoing loss (§1) and describes the populations at issue (§2); it situates the endpoint assumption in the English-language literature and specifies precisely what kind of endpoint is in question (§3); it sets out the model's provenance and translation problem (§4), its three dimensions (§5) and four principles (§6); it analyzes the ongoing nature principle and defends the extension to loss before death (§7); it derives from the model's own structure a distinction between endpoint-less grief and pathological grief (§8); it states the model's evidentiary limits (§9); and it draws implications for chaplaincy assessment, documentation, and pastoral posture (§10). Throughout, claims about the English-language literature are limited to the frameworks examined, and no claim is made that the DNA Model is the only framework capable of these tasks—only that, among the frameworks reviewed, it states the relevant principle with a directness the others do not.

2. Ongoing Loss: Where an Endpoint Cannot Hold

The living losses at issue are not exotic. In most acute-care hospitals they are the chaplain's ordinary caseload. What unites them is not their content but their temporal structure: the loss is not an event located in the past but a process still underway. Charmaz [6] named the central phenomenon *loss of self*—the crumbling of former self-images without equally valued replacements—and identified the structural reason clinical systems handle it badly: chronic illness is managed within an acute-care framework designed for conditions that conclude. Bury [7] described the same rupture as biographical disruption. Mishel [8] theorized what abiding uncertainty does to time, abandoning equilibrium as the theoretical goal and proposing instead an orientation in which ongoing uncertainty is received as "the natural rhythm to life" [8] (p. 257). Frank [9] supplied the narrative correlate: the restitution story collapses, and the teller must inhabit a chaos narrative that offers no arc.

Boss [3] [10] developed the theory of ambiguous loss, naming the caregiving instance frozen grief—mourning that cannot begin because the loss is incomplete and cannot end because it continues. Resilience in ambiguous loss, she writes, means "increasing one's tolerance for ambiguity" [10] (p. 272): not the attainment of clarity but the capacity to hold contradictory truths at once. Eakes and colleagues [11], developing Olshansky's [12] chronic sorrow into a middle-range theory, characterize it plainly as a "normal response to an abnormal situation" [11] (p. 180); Roos [2] insists on its nonpathological status. Where losses accumulate faster than grief can integrate them—the condition Kastenbaum [13] termed bereavement overload—sustained grief also outlasts social tolerance, generating what Doka [14] calls disenfranchised grief, which is "not or cannot be openly acknowledged, publicly mourned, or socially supported" [14] (p. 5).

Four features recur: loss accumulates before prior grief settles; there is no discrete before and after; the losses implicate the self rather than only external relationships; and grief outlasts the tolerance of those around the griever. A framework adequate to these situations must be able to describe grief that does not end without thereby describing pathology. For reasons rooted in its own history, the English-language frameworks examined here largely do not provide such a description.

3. The Endpoint Assumption in English-Language Grief Theory

The frameworks discussed in this section were selected as the most influential in English-language grief theory and clinical training; the review is purposive rather than systematic, and its conclusions are accordingly limited to the frameworks examined. On the question of an endpoint, these frameworks divide into those that assume one and those that defer one. The psychoanalytic inheritance [15], the stage sequence popularly drawn from Kübler-Ross [16], and the task model of Worden [17] all assume a terminus: detachment achieved, acceptance reached, tasks completed. Each measures grief as distance from that terminus.

The frameworks usually credited with escaping this inheritance retain the endpoint in a subtler form. Continuing bonds theory [18] demonstrated that sustained relationship with the dead is normative rather than pathological, but the field relocated rather than removed the criterion: the bond is licensed by the degree to which the death has been, in Root and Exline's [19] terms, subject to "recognition and incorporation ... into ... ongoing life" [19] (p. 4). Meaning reconstruction [20] ties the legitimacy of grief to meaning made, yet Park [21] reports that "a substantial minority of people do not report meaning making" [21] (p. 288) after loss. The Dual Process Model [22] [23] reclassified respite from avoidance to regulatory necessity—a genuine advance—but predicted that attention would "gradually (and unevenly)" shift from loss toward restoration [23] (p. 283), a longitudinal drift that functions as a terminus in slow motion.

Precision about the word *endpoint* is essential here, because the claim is easily misread as denying something the article does not deny. By an endpoint this article means a normative terminal state at which grief is treated as *completed*—variously operationalized across the literature as the relinquishment or severance of the bond with what was lost, the point at which the loss ceases to shape the person's ongoing life, or "recovery" and "resolution" understood as terminal achievements against which continued grief counts as failure. It is this terminus that the DNA Model denies. The denial does not extend to two distinct and well-documented phenomena with which the model is fully compatible: the *reduction in the intensity of acute grief* over time, and the *recovery of daily functioning*. That the sharpest pain of a loss commonly softens, and that most people resume work, relationships, and ordinary activity, are empirical regularities the model neither disputes nor needs to dispute. What it denies is only that these changes constitute

arrival at a state in which the loss no longer matters or the bond is dissolved. A person may function well, may feel the acute edge of grief less often, and still be—permanently and without pathology—someone shaped by an ongoing loss. Separating the normative terminus from the empirical softening of acute grief is what makes the critique precise: its target is the standard, not the observation.

The common structure of the deferral frameworks is that the endpoint is postponed, relocated, or made gradual, but retained, and a deferred endpoint still licenses the question of whether a person is arriving. In ongoing loss that question has no benign answer, because the loss dimension is continuously replenished and there is nothing to arrive at. What the frameworks examined do not contain is one that denies the endpoint outright while affirming the softening of acute grief. That is what the DNA Model supplies.

4. The DNA Model: Provenance and the Translation Problem

Verthriest and Maes [4] published *Het DNA van rouw: Eigentijdse handleiding voor het omgaan met rouw en rouwenden*—"The DNA of Grief: A Contemporary Guide to Dealing with Grief and the Grieving"—with the Flemish publisher Witsand Uitgevers. It was written as a handbook for practitioners and bereaved persons in the Low Countries, and it is little known outside its language. Its interest for the present argument is that, among the frameworks reviewed here, it is the one in which the denial of an endpoint is a stated first principle rather than an inference drawn by sympathetic readers.

Two cautions attend its introduction to English-language scholarship. First, no English translation exists; the renderings here are the author's own translations from the Dutch, and the Dutch original of the load-bearing formulation is supplied below so that readers competent in the language may assess it directly. Second, the model has been cited in passing in the author's prior work [5] but has never received sustained exposition; the present article offers that exposition while making no claim that the model has been empirically validated. It is presented as a theoretical resource whose contribution is conceptual, and §9 states its limitations without mitigation.

5. Three Simultaneously Active Dimensions

The model holds that grieving persons navigate three dimensions at once, and that these dimensions constitute the structural code of the grief experience—hence its name. Just as biological DNA specifies the structure of a unique organism, the three strands intertwine like a double helix to compose the particular shape of a given person's grief [4]. The metaphor is more than decorative. A helix has no terminal residue by which its progress is measured; its strands are coextensive along its whole length. Where stage models ask which stage a person occupies, and where oscillation models ask which pole a person is oriented toward, the DNA Model asks how three permanently active strands are presently configured. The question has no correct answer, only an accurate one. **Table 1** summarizes the

three dimensions and the chaplaincy attention each invites.

Table 1. The three dimensions of the DNA model.

Dimension	What it comprises	Focus of chaplaincy attention
Connection	Bonds sustained with what is lost: memory, internal conversation, ritual, sensed presence, values and legacy; may attach to a person or a lost aspect of self	How the bond is carried and transformed; whether it can be occupied and also left
Loss	Direct confrontation with absence: separation pain, disruption, erosion of what was; continuously replenished in ongoing loss	Whether the person can enter this dimension and also leave it, rather than being saturated by or foreclosed from it
Life continues	Ongoing life alongside grief—its demands, relationships, and possibilities; neither betrayal nor moving on	Access to ordinary engagement without treating it as disloyalty

Note: The three dimensions are permanently and simultaneously active; adaptation is a matter of which dimensions the person can access and how freely, not of progress toward an endpoint.

5.1. Connection

The *connection dimension* comprises the ways a bond is sustained with what has been lost—cherished memory, internal conversation, ritual, sensed presence, and the carrying forward of shared values or legacy. The dimension may attach to a deceased person or to a lost aspect of the self. Crucially, the DNA Model treats such connection as healthy, normal, and potentially permanent, requiring no justification by its contribution to adaptation. The orientation converges with Neimeyer's [20] account of grief work as helping the bereaved "retain and reconstruct rather than relinquish the bond" [20] (p. 87), and with longitudinal research indicating that the search for significance in loss is not completed but transformed over time [21] [24].

5.2. Loss

The *loss dimension* comprises direct confrontation with absence: the pain of separation, the disruption of a shared world, the erosion of what was. In episodic bereavement this dimension can in principle recede as the loss settles into the past. In ongoing loss it cannot, because it is continuously replenished—by each new deficit, each new item of prognostic information, each further absence that the underlying condition produces. The dimension does not close; it is refilled.

5.3. Life Continues

The *life continues dimension* acknowledges that the person goes on living even where the world has become unrecognizable, and that this continuation is neither betrayal nor moving on. Life and grief coexist in a permanent, dynamic interaction rather than succeeding one another [4]. Engagement with ongoing life is not evidence that the bond has been relinquished, and withdrawal from it is not evidence of fidelity; the dimension is simply one of the three strands that are always, to some degree, in play.

6. Four Guiding Principles

Four principles govern the model's use. The first three situate grief; the fourth, treated separately in §7, carries the argument. Table 2 states the four in summary.

Table 2. The four guiding principles of the DNA model.

Principle	Claim
Multidimensionality	The three dimensions are navigated simultaneously, not in sequence.
Individuality	Grief is shaped by the particular relationship lost and by culture, personality, resources, and circumstance.
Contextuality	Expression of grief varies across social settings; such variation is normal adaptation, not avoidance or inauthenticity.
Ongoing nature	Grief has a beginning but no end for as long as the bereaved person lives.

Note: The ongoing nature principle is the model's distinctive commitment; the other three principles are shared, in part, with several contemporary frameworks.

6.1. Multidimensionality

Multidimensionality holds that the three dimensions are navigated simultaneously rather than sequentially. There is no stage at which connection gives way to loss, or loss to life-continuation; a person is, at any moment, somewhere within all three.

6.2. Individuality

Individuality holds that grief is shaped by the particular relationship that has been lost and by the mourner's culture, personality, resources, and circumstance. The model specifies a structure, not a content; what fills the three dimensions is irreducibly particular.

6.3. Contextuality

Contextuality holds that the expression of grief varies across social settings, and that such variation is normal adaptation rather than avoidance or inauthenticity. The principle is of direct consequence for chaplains, who frequently encounter a patient's grief in a register the family has not seen, and who must resist reading that difference as concealment or denial.

6.4. Ongoing Nature

Ongoing nature, the fourth principle, holds that grief has a beginning but no end for as long as the bereaved person lives. Because this principle both distinguishes the DNA Model from the frameworks surveyed in §3 and licenses the extension to loss before death, it is treated on its own below.

7. Denial, Not Deferral, and the Extension to Loss before Death

Verthriest and Maes [4] state the ongoing nature principle directly: "Rouw heeft

wel een beginpunt, maar geen eindpunt zolang de nabestaande zelf leeft" [4] (p. 61)—in the author's translation, mourning has a starting point, but no endpoint for as long as the survivor lives. They add that one never gets over the loss of a significant person: the mourner is colored by the experience for the remainder of life, and the loss is in turn colored by subsequent experience.

The formulation rewards careful reading, because its structure is unusual. It is not the claim that grief *may* persist, nor that persistent grief is *permissible*, nor that persistence is *adaptive under certain conditions*. Each of those leaves the endpoint standing as a norm from which exceptions are carved. Verthriest and Maes deny the endpoint as a property of grief as such. Mourning begins; mourning does not end; the mourner dies. As §3 was careful to specify, this denial concerns the normative terminus of completed grief and not the softening of acute grief, which the model grants. What the denial removes is the clock: there is no threshold against which *continues* could register as late.

The reciprocity clause is easily missed and equally important. The loss is colored by subsequent experience: grief here is not a fixed quantity that persists unchanged but a living relation continually reconstituted by the life the mourner goes on having. This is what allows the model to deny an endpoint without condemning the mourner to stasis—the objection most often and most reasonably raised against non-resolution accounts. To have no endpoint is not to be frozen; it is to remain in motion within a relation that keeps being remade.

This is where the extension flagged in §1 is earned rather than assumed. Verthriest and Maes state the principle for the bereaved—the survivor of a death—for whom mourning begins at the loss and continues for life. In ongoing loss the loss has not yet completed: the spouse is still alive though altered, the illness still progressing, the disability a permanent present rather than a past event. The extension holds, and holds *a fortiori*, for a structural reason. The ongoing nature principle denies an endpoint because the mourner is continually re-colored by a loss that keeps being re-encountered. Where the loss is not merely remembered but still occurring—where each visit brings a further decline—the condition the principle describes is intensified rather than weakened, because the loss dimension is replenished by present events and not only by memory. If grief can have no endpoint after a death because the relation keeps being remade, it can have no endpoint during a loss that is itself still unfolding. The extension is therefore not a loosening of the model but an application of its own logic to the case that tests it most severely. One caution is directional: because the loss is incomplete, anticipatory and ambiguous elements are present that post-death bereavement lacks [10], and the model's dimensions must be read as tracking a moving rather than a settled loss.

8. Distinguishing Endpoint-Less Grief from Pathological Grief

The strongest objection to any non-resolution account is that it risks legitimizing

permanent suffering—that in denying grief an endpoint it removes the very standard by which unhealthy grief is recognized, and blurs the line separating normal ongoing grief from prolonged grief disorder and other states that call for professional intervention. The objection is serious, and it cannot be met by appending a referral clause at the end of the argument. It must be met, if at all, from within the model's own structure. This section argues that the DNA Model's structure supplies the needed distinction, even though the model does not itself make it explicit.

It should be conceded first that the model, as published, specifies no criterion of pathological grief; its authors describe the healthy structure of mourning and leave its failure modes untheorized. The distinction offered here is therefore a reading—an entailment of the model's commitments rather than a claim its authors advance. But the entailment is straightforward. The model's account of health rests on two features: the simultaneous accessibility of all three dimensions (multidimensionality), and the reciprocity by which grief is continually reconstituted by the ongoing life of the mourner (the second clause of the ongoing nature principle). Pathology, on this reading, is the collapse of exactly these features. It appears as *saturation* in the loss dimension to the exclusion of the others—a person who can enter loss but not connection or ongoing life; as *foreclosure* of a dimension—a bond wholly refused, or a life that cannot be re-entered; and as the *failure of reciprocity*—grief that has ceased to be a living relation continually remade and has become a fixed quantity, frozen at a single configuration. Boss's [10] frozen grief names precisely this collapse. Table 3 sets the two states side by side.

Table 3. Endpoint-less grief and pathological grief distinguished within the DNA model.

Feature	Healthy endpoint-less grief	Pathological grief
Dimensional access	All three dimensions remain accessible	One dimension saturated (usually loss) or foreclosed (connection or life continues)
Movement among dimensions	The person can move among the three	Fixation: cannot leave one dimension, or cannot enter another
Reciprocity	Grief continually reconstituted by ongoing life	Grief frozen as a fixed quantity; reciprocity failed

Note. The distinction turns on configuration and reversibility, not on duration: a decades-long grief may be healthy, and a brief one pathological.

This yields a distinction that does the work the endpoint standard was wrongly asked to do. What separates healthy endpoint-less grief from pathological grief is not *duration*—the criterion the endpoint assumption smuggles in, and the one that misreads the wife of the man with dementia as failing after three years—but *configuration and reversibility*: whether the three dimensions remain accessible, and whether the person can move among them, or whether one dimension has become a prison. A grief that persists for decades while the person moves among connection, loss, and ongoing life is, on the model's terms, healthy however long it lasts. A grief of a few months that has foreclosed connection and ongoing life

and saturated in loss is, on the model's terms, in trouble however short. Duration decides neither.

This is also where the model's relation to prolonged grief disorder becomes clear. The DSM-5-TR category [25] and its validation literature [26] identify grief that is persistent, pervasive, and functionally impairing. The DNA Model does not dispute that such states exist or that they warrant care; it disputes only the inference from persistence *as such* to pathology. On the reading offered here, what makes the impairing cases impairing is not that grief continued but that its dimensional structure collapsed—which is why a duration threshold will tend both to over-identify, flagging sustained but well-configured grief in ongoing loss, and to under-identify, missing early foreclosure. Far from legitimizing permanent suffering, the model supplies a sharper marker of it: suffering that has foreclosed connection and ongoing life and frozen the mourner in the loss dimension is exactly the state the model identifies as its own failure mode, and exactly the state for which the chaplain should facilitate psychiatric referral. The nosological argument is developed separately [27]; the point here is only that the boundary can be drawn from inside the model, and that drawing it there is what prevents "no endpoint" from collapsing into "no standard."

9. Evidentiary Status and Limitations

Candor about what the DNA Model is not is essential to any responsible introduction of it. It was published in 2017 by a Flemish trade press, not in a peer-reviewed venue. It has no longitudinal evidence base, no psychometric instrumentation, no established reliability or validity, and no cross-cultural testing outside the Dutch-speaking context. By the ordinary standards of the evidence hierarchy it does not yet count as evidence at all, and the single-source, single-language basis of this exposition compounds the caution: the reading offered here is the author's own translation of one non-peer-reviewed text, and the distinction drawn in §8 is an entailment the model's authors do not themselves state.

Three considerations nevertheless justify its introduction to English-language chaplaincy. First, its contribution is conceptual, and conceptual contributions are assessed by coherence and explanatory adequacy rather than by effect size. Second, among the frameworks reviewed here, the ongoing nature principle states the denial of an endpoint with a directness the others do not; this is a claim about the literature examined, not a claim of absolute originality. Third, the model converges independently with the Dual Process Model on the rejection of linear progression, and convergence from two theoretically unrelated traditions constitutes a form of warrant, if a weak one. The appropriate conclusion is that the DNA Model should be treated as a hypothesis-generating framework and a resource for clinical reasoning, not as an empirically supported intervention. A formal English translation with scholarly apparatus, and empirical work operationalizing the three dimensions and testing the configuration-based distinction of §8, remain needed.

10. Implications for Chaplaincy Practice

A conceptual framework earns its place in chaplaincy only if it changes what a clinician does. Three implications follow from taking the DNA Model as the operative model of grief in ongoing loss.

10.1. Assessment

If grief is the simultaneous configuration of three permanently active dimensions, the chaplain's assessment question is not *how far along is this person* but *which dimensions can this person presently access, and how are the three configured*. The relevant findings, as §8 argued, are foreclosure of a strand and saturation in a strand—and the reversibility of either—not the mere persistence of grief. A patient who can occupy the connection dimension by reminiscing, addressing the absent person, or tending a ritual, who can also engage the life-continues dimension, and who can move between them, is exercising a competence rather than failing to arrive. The GRIEF Model [5] operationalizes this premise, mapping all three dimensions across the patient's loss categories and evaluating the connection dimension directly.

10.2. Documentation

Chaplaincy documentation is the point at which a grief model becomes an institutional fact. The sentence "continues to struggle with acceptance" is not a description of a patient but a theory about grief, asserted in a record clinicians have no occasion to interrogate. The three dimensions supply a vocabulary for recording what was actually observed. In place of *continues to struggle with acceptance*: *Wife sustaining connection with husband's pre-illness identity while managing present care demands; engages ongoing life without treating it as betrayal.* In place of *patient in denial*: *Patient presently oriented to the life-continues dimension; able to enter the loss dimension when invited, and to leave it.* These are not euphemisms. They are more accurate, they are falsifiable, and they do not smuggle a prognosis for grief into a record that has no business containing one.

10.3. Pastoral Posture

Taken as the operative model, the DNA Model licenses a posture the resolution inheritance does not—but the posture must be held with care, and the care is the point. That grief has no endpoint is a clinical truth, not a reassurance to be offered lightly, and never a line to lead with. It has standing only as *naming*: the recognition of something the patient's own experience is already disclosing. It has none as *prophecy*, a future pronounced over a person who has not asked for it. Told to someone still hoping for relief, in the wrong hour, "this will not end" is not honesty but cruelty. The posture the model licenses is therefore not the announcement that the loss will not end but the readiness to receive that recognition when the patient arrives at it, and to meet it without correction—to let "this will not stop hurting" be heard as accurate rather than hurried toward acceptance.

The model supplies the permission and the vocabulary; it does not supply the occasion, and it is the clinician's judgment, not the model, that decides when the truth may be said and when it must be kept. The internal capacities that make such threshold-dwelling sustainable, for patient and chaplain alike, are developed elsewhere [28].

None of this disputes that grief can resolve where the loss is finite, or that psychiatric intervention is sometimes necessary. As §8 argued, the model's own structure marks the states that warrant referral, and prolonged grief disorder [25] [26] identifies a real population in real need; timely referral remains part of the chaplain's role. What the DNA Model changes is the default against which ongoing grief is read, and the location of the boundary—in dimensional configuration rather than duration. It specifies grief's dimensional content but not the mechanism by which attention moves among the dimensions; the Dual Process Model supplies that mechanism but not a non-teleological temporality, and their integration is developed in separate work and not presupposed here.

11. Conclusions

English-language grief theory, sorted by the question of an endpoint, resolves—among the frameworks examined—into those that assume a terminus and those that defer one. The DNA Model of Verthriest and Maes [4] belongs to neither group: it denies the endpoint, and denies it as a first principle. So far as the reviewed literature shows, it states this commitment with a directness no English-language framework matches, which is what recommends it for the grief of those whose loss has not stopped happening. The model's evidentiary base is thin; its exposition here rests on a single translated source, and the distinction between healthy endpoint-less grief and pathological grief has been drawn as an entailment its authors do not themselves state. These are real limits, and they bound the claim to what it is: a conceptual proposal offered for testing, not a validated instrument.

What is less in doubt is the difference the default makes at the bedside. The wife of the man with Huntington's disease will visit again tomorrow. Nothing in this article changes what she faces. What it can change is the sentence written about her—whether she is recorded as failing to accept, or recognized as three years into a loss that has not finished, moving among the man he was, the man he is, and the life she must go on having. A model that denies grief an endpoint is what allows the chart to say the latter—carefully, and only when it is true.

Related Prior Work

This article is part of a series developing a recognition-oriented account of grief in ongoing loss. The articles Mussche (2026) [5] [27] [28] address, respectively, the nosological critique of prolonged grief disorder, spiritual assessment through the GRIEF Model, and the construct of liminal competence; a reflective essay by the author has appeared in *Presence*. The integration of the DNA Model with the Dual Process Model is developed in a separate manuscript in preparation. The

present article does not overlap substantively with these works: its contribution is the first sustained English-language exposition of the DNA Model itself.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

References

[1] Bruce, E.J. and Schultz, C.L. (2001) Nonfinite Loss and Grief: A Psychoeducational Approach. Paul H. Brookes Publishing.

[2] Roos, S. (2002) Chronic Sorrow: A Living Loss. Brunner-Routledge.

[3] Boss, P. (2000) Ambiguous Loss: Learning to Live with Unresolved Grief. Harvard University Press.

[4] Verthriest, G. and Maes, J. (2017) Het DNA van rouw: Eigentijdse handleiding voor het omgaan met rouw en rouwenden. Witsand Uitgevers.

[5] Mussche, T. (2026) The GRIEF Model: A Recognition-Based Framework for Spiritual Assessment in Contexts of Ongoing Loss. *Open Access Library Journal*, **13**, e15502. https://doi.org/10.4236/oalib.1115502

[6] Charmaz, K. (1983) Loss of Self: A Fundamental Form of Suffering in the Chronically Ill. *Sociology of Health & Illness*, **5**, 168-195. https://doi.org/10.1111/1467-9566.ep10491512

[7] Bury, M. (1982) Chronic Illness as Biographical Disruption. *Sociology of Health & Illness*, **4**, 167-182. https://doi.org/10.1111/1467-9566.ep11339939

[8] Mishel, M.H. (1990) Reconceptualization of the Uncertainty in Illness Theory. *Image: The Journal of Nursing Scholarship*, **22**, 256-262. https://doi.org/10.1111/j.1547-5069.1990.tb00225.x

[9] Frank, A.W. (2013) The Wounded Storyteller: Body, Illness, and Ethics. 2nd Edition, University of Chicago Press.

[10] Boss, P. (2016) The Context and Process of Theory Development: The Story of Ambiguous Loss. *Journal of Family Theory & Review*, **8**, 269-286. https://doi.org/10.1111/jftr.12152

[11] Eakes, G.G., Burke, M.L. and Hainsworth, M.A. (1998) Middle-Range Theory of Chronic Sorrow. *Image: The Journal of Nursing Scholarship*, **30**, 179-184. https://doi.org/10.1111/j.1547-5069.1998.tb01276.x

[12] Olshansky, S. (1962) Chronic Sorrow: A Response to Having a Mentally Defective Child. *Social Casework*, **43**, 190-193. https://doi.org/10.1177/104438946204300404

[13] Kastenbaum, R. (2000) The Psychology of Death. 3rd Edition, Springer.

[14] Doka, K.J. (2002) Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice. Research Press.

[15] Freud, S. (1957) Mourning and Melancholia. In: Strachey, J., Ed., *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. 14, Hogarth Press, 237-258. (Original Work Published 1917)

[16] Kübler-Ross, E. (1969) On Death and Dying. Macmillan.

[17] Worden, J.W. (2018) Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner. 5th Edition, Springer. https://doi.org/10.1891/9780826134752

[18] Klass, D., Silverman, P.R. and Nickman, S.L. (1996) Continuing Bonds: New Understandings of Grief. Taylor & Francis.

[19] Root, B.L. and Exline, J.J. (2013) The Role of Continuing Bonds in Coping with Grief: Overview and Future Directions. *Death Studies*, **38**, 1-8. https://doi.org/10.1080/07481187.2012.712608

[20] Neimeyer, R.A. (2019) Meaning Reconstruction in Bereavement: Development of a Research Program. *Death Studies*, **43**, 79-91. https://doi.org/10.1080/07481187.2018.1456620

[21] Park, C.L. (2010) Making Sense of the Meaning Literature: An Integrative Review of Meaning Making and Its Effects on Adjustment to Stressful Life Events. *Psychological Bulletin*, **136**, 257-301. https://doi.org/10.1037/a0018301

[22] Stroebe, M. and Schut, H. (1999) The Dual Process Model of Coping with Bereavement: Rationale and Description. *Death Studies*, **23**, 197-224. https://doi.org/10.1080/074811899201046

[23] Stroebe, M. and Schut, H. (2010) The Dual Process Model of Coping with Bereavement: A Decade on. *OMEGA*: *Journal of Death and Dying*, **61**, 273-289. https://doi.org/10.2190/om.61.4.b

[24] Gillies, J. and Neimeyer, R.A. (2006) Loss, Grief, and the Search for Significance: Toward a Model of Meaning Reconstruction in Bereavement. *Journal of Constructivist Psychology*, **19**, 31-65. https://doi.org/10.1080/10720530500311182

[25] American Psychiatric Association (2022) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). https://doi.org/10.1176/appi.books.9780890425787

[26] Prigerson, H.G., Boelen, P.A., Xu, J., Smith, K.V. and Maciejewski, P.K. (2021) Validation of the New DSM-5-TR Criteria for Prolonged Grief Disorder and the PG-13-Revised (PG-13-R) Scale. *World Psychiatry*, **20**, 96-106. https://doi.org/10.1002/wps.20823

[27] Mussche, T. (2026) Beyond Twelve Months: Prolonged Grief Disorder and the Pathologization of Ongoing Loss. *Open Access Library Journal*, **13**, e15553. https://doi.org/10.4236/oalib.1115553

[28] Mussche, T. (2026) Liminal Competence: An Original Construct for Sustainable Threshold-Dwelling in Ongoing Loss. *Open Access Library Journal*, **13**, e15552. https://doi.org/10.4236/oalib.1115552