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Staying With Grief: The STAY Framework as an Orienting Stance for Grief-Informed Psychotherapy

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Research Article

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Abstract

Grief frequently presents across clinical settings, often unlabeled and embedded within concerns such as anxiety, burnout, depression, or stalled progress in treatment. Many health service psychologists receive limited training in recognizing and responding to grief outside bereavement-focused care. This article introduces the STAY framework (Slow Down, Track the Loss, Allow Complexity, Yield to the Moment) as an orienting stance for grief-informed psychotherapy that complements existing evidence-based treatments. Through composite vignettes, the article reviews contemporary grief theory, clinical and ethical challenges related to access and equity, and practical guidance for assessment, differentiation of prolonged grief disorder, and application across clinical, workplace, and family settings.

Clinical Vignettes

Case 1

Alex, a 46-year-old project manager, presented to therapy with emotional exhaustion, irritability, and difficulty concentrating at work. For nearly two years, Alex had been the primary caregiver for a parent living with a progressive neurodegenerative illness while also parenting two school-aged children. Alex is the eldest child in a close, multigenerational family in which caring for aging parents at home is both an expectation and a source of pride. After the parent's death four months earlier, Alex took the three days of bereavement leave the employer offered and returned to work the following week. The referral from Alex's primary care provider read "burnout, rule out depression." Alex described feeling "completely depleted" and frustrated at not being able to return to previous levels of functioning.

In session, Alex moved between describing the practical demands of caregiving and downplaying the emotional impact of the loss. When the therapist gently reflected the significance of the parent's death, Alex responded, "Honestly, I feel more tired than sad," before shifting back to work and parenting. At other points, Alex shared guilt about a sense of relief now that caregiving had ended: "I should be more upset, but mostly I just feel… done."

The therapist noticed a pull to focus on stress management and restoring structure, given the ongoing demands at home and work. At the same time, grief was present in multiple forms: anticipatory loss that had begun long before the death, the loss of a caregiving role that had organized daily life, the loss of the parent Alex had known before the illness, and emotional responses that did not fit neatly into a single narrative.

Case 2

Riley, a 29-year-old graduate student, had been in therapy for several months for longstanding self-esteem concerns and social anxiety. Treatment followed a structured cognitive behavioral protocol, and Riley had been making steady progress on weekly symptom ratings.

During the course of therapy, Riley received a diagnosis of a chronic autoimmune condition after nearly two years of symptoms that several providers had attributed to stress and anxiety. Riley's student health plan covered only part of the specialty care the condition required, and Riley reduced their course load to manage fatigue and appointments. In the sessions that followed, Riley described increased withdrawal, heightened self-consciousness, and a growing sense of disconnection from activities that had once felt meaningful. Weekly anxiety scores rose. Riley said, "I don't recognize myself anymore," and struggled to find language for what the diagnosis had shifted.

Moments of emotional activation related to the diagnosis surfaced briefly and were often followed by a return to the established treatment agenda, sometimes initiated by Riley and sometimes by the therapist. The therapist noticed a pull to continue with familiar cognitive and behavioral strategies and to frame the change as a setback in progress, while also recognizing loss tied to identity, the body, future plans, and sense of self. The therapist also wondered whether

Riley's earlier experiences of medical dismissal were shaping how safe it felt to bring distress about the body into yet another clinical relationship.

Both vignettes are composites. Together they illustrate grief that arrives unlabeled, after a death and in the middle of treatment for something else, and both are discussed throughout the article.

Key Background on Topic

Grief Beyond Death

Grief is the response to the loss of any attachment, role, identity, or future expectation (Doka, 2002; Harris, 2020). It is most often associated with death, yet it emerges just as reliably in response to changes in health, relationships, roles, and life plans. Three terms are important to define for shared language and understanding. *Grief* is the internal response to loss and is unique to each person; *bereavement* is the loss event itself, most often used in reference to a death; *mourning* is the outward expression of grief, shaped by culture, faith, and community (Stroebe et al., 2008; Zisook & Shear, 2009). Boss (1999) described *ambiguous loss* as loss that lacks the clarity or resolution of death, such as a loved one who is physically present but psychologically absent, yet carries comparable emotional weight. Doka (2002) described *disenfranchised grief* as grief that is not openly acknowledged, socially sanctioned, or publicly mourned.

Clients rarely seek therapy specifically for grief related to ambiguous or non-death losses, and many who have experienced a death do not name grief as their reason for seeking care (Piper et al., 2001). Among 55,728 students seen at college counseling centers, clinicians identified grief or loss as a concern for 10.8% after the initial appointment but as the primary concern for only 3.1% (Center for Collegiate Mental Health, 2026). Grief tends to be embedded within, or masked by, presenting concerns such as anxiety, irritability, burnout, low mood, or stalled progress in treatment. Alex was referred for burnout; Riley's grief first appeared as a rise in anxiety scores. In both cases, grief was present without being identified by the client, and it could easily have gone unidentified by the clinician as well.

Research with adults points to the same pattern and to a gap in care. In a study of 729 adults at psychiatric outpatient clinics, more than half had experienced the death of someone significant, about one third met criteria for moderate or severe complicated grief, and loss was rarely the reason patients gave for seeking treatment, tending instead to emerge later in care (Piper et al., 2001). More recently, among bereaved adults referred to outpatient clinics for anxiety, depression, or posttraumatic stress, roughly one third met criteria for prolonged grief disorder, with markedly higher rates among patients with refugee backgrounds (Groen et al., 2026). Grief that goes unnamed can also go untreated. In a study of bereaved caregivers, most of those who met criteria for prolonged grief disorder had not accessed mental health services, and the only significant predictor of later service use was having previously discussed psychological concerns with a health care provider (Lichtenthal et al., 2011). Taken together, these findings suggest that grief is often present in clinical care before it is named, and that asking about it may be what opens the door to support.

From Stages to Integration

Many clinicians and clients first learned about grief through stage models (Schuurman & Mitchell, 2020). Kübler-Ross (1969) developed the five stages from interviews with people who were dying rather than people who were bereaved, and the model was never intended to be prescriptive. In practice, however, the stages became a template for how grief should unfold, implying linearity, an endpoint, and a right and wrong way to grieve. Clients who grieve differently are then described as stuck, in denial, or not processing.

The field has since moved toward more flexible and integrative understandings. The dual process model describes adaptive grieving as an oscillation between loss-oriented coping, which involves engaging with the loss, and restoration-

oriented coping, which involves attending to the changed demands of daily life (Stroebe & Schut, 1999). A good day after a terrible one is not denial; the movement between the two is healthy. Meaning reconstruction perspectives emphasize how people make sense of loss and integrate it into an evolving identity and worldview (Neimeyer, 2001). Continuing bonds theory challenges the assumption that adaptation requires detachment, highlighting the ongoing relationship people maintain with who or what they have lost (Klass et al., 1996).

Together, these frameworks reflect a shift away from resolution and toward grief integration. Grief does not go away; it evolves, and grievers learn to carry it and weave their lived experience of loss into their stories. The clinical aim is not closure. It is integration.

Neuroscience has deepened this understanding. O'Connor (2022) describes grief as a form of learning: the brain has encoded an attachment, along with the expectation that the person will be there and updating that cognitive map takes time and repeated experience. This helps explain why grief resurfaces with reminders and anniversaries. A recent systematic review of 58 studies found consistent evidence of psychological, physical, and mortality effects clustered around bereavement anniversaries (Leaune et al., 2025). Grief touches every domain of functioning: physical (fatigue, somatic distress), emotional (sadness, anger, guilt, yearning), cognitive (fog, disbelief, intrusive thoughts), behavioral (withdrawal, changes in sleep and appetite), social (isolation, conflict), and spiritual or existential (disrupted meaning or faith; Schuurman & Mitchell, 2020; Worden, 2009). Because these domains overlap with symptoms of depression, anxiety, and adjustment disorders, grief is easily misread (Shear, 2015; Zisook & Shear, 2009).

Polyvagal theory offers a useful lens for pacing. Dana (2018) describes how the autonomic nervous system responds to loss and disconnection, and how co-regulation within the therapeutic relationship supports stabilization and integration. From this perspective, pacing is not a technique; it is an attuned response to the client's nervous system state. Co-regulating with a grieving client is difficult when the clinician has not been trained to recognize grief or to apply contemporary grief concepts in session.

The Training Gap

Despite these advances, most mental health providers receive limited formal preparation in grief counseling and rely on outdated or simplified models, which leaves supervision as the primary place where grief competencies are, or are not, developed (Akmese & Ercevik, 2026). Schuurman and Mitchell (2020) called for a professional shift toward grief-informed practice that extends beyond specialized bereavement settings into everyday care. Grief is often treated as belonging in a separate lane, leaving generalist clinicians underprepared to recognize it within other presenting concerns (Office of the Assistant Secretary for Planning and Evaluation, 2023). As a result, grief is overlooked, minimized, pathologized, or translated into more familiar diagnostic categories (Piper et al., 2001; Wakefield, 2013). Clinicians today are often quick to understand distress through a trauma lens, and trauma-informed care is essential. A prior question is also worth asking: What becomes visible when what is presenting clinically is first considered through a grief lens? Ivers et al. (2024) made a related argument, critically comparing prolonged grief disorder criteria with existential principles and urging clinicians to understand and treat grief phenomenologically and relationally rather than through diagnostic criteria alone. From this perspective, many symptoms of prolonged grief can be understood in relation to the existential givens of death anxiety, freedom, isolation, and meaning or meaninglessness, which gives clinicians a way to understand those symptoms that extends beyond diagnosis (Ivers et al., 2024). Clinicians are also trained to move toward intervention, and those skills can be applied too quickly when grief is present. Grief is layered and often contradictory, and holding this complexity requires a clinical orientation that prioritizes presence over productivity.

STAY: An Orienting Stance for Grief-Informed Care

The STAY framework was developed to help close the gap between contemporary grief science and everyday clinical practice. STAY names four interrelated clinical movements: Slow Down, Track the Loss, Allow Complexity, and Yield to the Moment (Table 1). It is an orienting stance rather than a technique or a treatment protocol. Rather than prescribing what grief should look like or where it should lead, STAY orients the clinician to the many ways grief changes the griever, including identity, relationships, roles, the body, security, and meaning, and to the practice of leaning toward conversations about grief rather than away from them. It shapes how a clinician listens, assesses, conceptualizes, and paces care when grief is present, and it is designed to be used alongside the clinician's existing theoretical orientation and evidence-based treatments rather than in place of them. Its central premise is that when grief enters the room, the clinician's first task is to lean toward it rather than away from it, and to stay.

Table 1 *The STAY Framework: Components, Clinical Aims, and Practice Examples*

Component	Clinical aim	In practice	Sample language
Slow Down	Reduce urgency; create space rather than fill it	Regulate your own nervous system first; honor silence; notice when you are moving faster than the client	"What do you need right now?"
Track the Loss	Identify primary, secondary, hidden, and cumulative losses	Map roles, identity, future expectations, relationships, and community; listen for identity language	"What else has changed since then?"
Allow Complexity	Hold contradiction without resolving it	Validate both/and experiences; avoid pressure toward acceptance or reframing; honor continuing bonds	"Both of those can be true at the same time."
Yield to the Moment	Follow grief's rhythm rather than the agenda	Hold structure lightly; pause the plan collaboratively; return to skills when the client is ready	"We can set the plan aside today. This feels like where we need to be."

Note. STAY moves clinicians away from urgency, fixing, minimizing, pathologizing, prescribing, and avoiding, and toward attunement, presence, validation, curiosity, complexity, and pace. STAY is an orienting stance used alongside existing evidence-based treatments; it is not a stand-alone protocol.

STAY draws on established foundations. Its emphasis on presence and attunement reflects the therapeutic conditions described by Rogers (1957) and the research on therapeutic presence (Geller & Greenberg, 2012). Its attention to pacing draws on polyvagal-informed practice (Dana, 2018). Tracking the loss operationalizes ambiguous and disenfranchised loss (Boss, 1999; Doka, 2002) along with meaning reconstruction (Neimeyer, 2001), and allowing complexity reflects the dual process model and continuing bonds (Klass et al., 1996; Stroebe & Schut, 1999). STAY has not yet been evaluated empirically as a distinct framework; it is offered here as a clinically derived, integrative stance whose components rest on established theory and research. Because it is a stance rather than a protocol, it is accessible across professional settings and roles, including the therapy office, integrated primary care, long-term care, the workplace, schools, family systems, and clinical supervision.

Clinical and Ethical Challenges

One of the central challenges in grief-informed care is internal to the clinician: the pull to do something (Geller & Greenberg, 2012; Schuurman & Mitchell, 2020). When grief enters the room, clinicians often feel an impulse to reassure, reframe, problem-solve, or redirect toward established goals. For Alex's therapist, that pull appeared as a well-intentioned focus on stress management; for Riley's, it appeared as a return to the cognitive behavioral agenda. Neither response was wrong. Applied too early, both risked communicating that grief was a detour from the real work. Clinician

discomfort with sustained sadness, silence, or ambivalence is normal; it is not a signal to fix. Recognizing that pull, and regulating it, is itself a clinical skill.

Pathologizing and Minimizing

The inclusion of prolonged grief disorder (PGD) in the *DSM-5-TR* (American Psychiatric Association, 2022) gives clinicians a validated way to identify grief that persists, dominates, and impairs, and it opens access to targeted treatment. It has also raised concern that normative grief will be medicalized (Wakefield, 2013). The ethical task runs in both directions. Clinicians are asked to avoid labeling normative grief as disorder while remaining alert to grief that has become impairing or that co-occurs with depression, posttraumatic stress, suicidality, or substance use. Suicide bereavement illustrates the stakes: among 161 adults bereaved by suicide, 22% met criteria for PGD, 5% for posttraumatic stress disorder (PTSD), and 12.4% for complex PTSD, and 41.6% reported moderate to severe depressive symptoms (Hofmann & Wagner, 2025). These findings underscore the need for careful assessment when a loss is sudden, violent, or stigmatized. Diagnostic decisions also carry practical weight. Reimbursement often requires a diagnosis, and a label entered into a health record follows the client. Documentation that describes grief accurately, without converting normative grief into disorder for billing convenience, protects clients over the long term.

Clinicians working within time-limited, protocol-driven, or measurement-based models face a particular version of this challenge. Riley's rising anxiety scores could be read as treatment failure, when they more accurately reflected a new loss that the treatment plan did not yet account for. Structured treatment and grief-informed care are not in conflict, but a protocol can narrow what the clinician is able to see. Yielding to grief within a structured model means holding the structure lightly: pausing the agenda, naming the loss, collaboratively revising goals, and returning to skills when the client is ready. The principle of respect for people's rights and dignity, including self-determination (American Psychological Association [APA], 2017a), supports letting clients, rather than clinicians, set the meaning and pace of their grief.

Grief that includes relief, anger, or ambivalence is frequently disenfranchised, including by grievers themselves (Doka, 2002). Alex's relief after years of caregiving was normative and, for Alex, shameful. Clients grieving an estranged family member, a complicated relationship, a death by overdose or suicide, a pregnancy loss, or an ending they chose may doubt whether their grief is legitimate. When clinicians convey, even subtly, that a client should feel more sadness, less anger, or more acceptance, they reinforce that disenfranchisement.

Access, Equity, and Inclusion

Grief is profoundly cultural. Imposing dominant Western, individualist grief norms risks silencing diverse grief expressions and misreading them as pathology (APA, 2017b). Alex's family valued caring for elders at home; that value shaped the relief, exhaustion, and guilt Alex carried, and it called for curiosity rather than interpretation. Cultural humility means following the client's framework rather than the clinician's.

Grief is also intersectional. Blueford and Adams (2021) describe trauma-informed grief counseling with older adults who are Black, Indigenous, and People of Color as attending to systemic oppression and cumulative loss while drawing on culturally grounded sources of strength. LGBTQ+ clients may grieve partners or chosen family whose relationships were not legally or socially recognized (Bristowe et al., 2016; Doka, 2002). Disabled clients and clients living with chronic illness may encounter ableist assumptions in care, including clinicians who overattribute distress to disability or dismiss its relevance, and their grief about the body may be treated as either excessive or inevitable (Harris, 2020; Wang et al., 2024). Riley's two years of symptoms attributed to stress reflect a pattern of medical dismissal that can shape whether a client trusts a new clinician with distress about the body.

Structural conditions also shape who gets to grieve. Bereavement leave in the United States is not federally mandated; where it exists, it is often brief and may not extend to hourly workers, chosen family, or non-death losses. Clinicians can hold the questions that structural conditions answer for clients long before they reach a therapy office: Who can afford to fly home for the funeral? Who can afford to miss a shift? Who has a therapist, and who is months down a waitlist? Who is believed when they say they cannot function right now? Grief is not only unequally experienced; it is unequally resourced. Consider two clients with the same loss on paper who are in very different places six months later. The difference may have little to do with resilience. One received paid time off, financial cushion, meals on the porch, and a community that recognized the loss; the other received three days of leave and an impatient supervisor. When the second client is still struggling at month eight, a diagnosis is readily available. This is how a disparity becomes a chart note, and how a normative response to an under-resourced loss becomes pathologized. Cost, insurance requirements, language access, caregiving demands, and the availability of clinicians who understand a client's cultural context further shape who receives grief-informed care. Telehealth expands access across distance and jurisdictions, yet it remains limited for clients without private space or reliable technology. Consistent with the principle of justice, grief-informed practice asks clinicians to notice whose losses are recognized, whose grief is supported, and who has access to care.

Clinicians are not immune to grief. Personal losses, vicarious grief absorbed from clients, and the strain of working within systems that offer grievers, and clinicians, little support all affect presence (Lipsky, 2009; Phillips et al., 2025). A scoping review of 81 publications found that professional grief among health care workers is pervasive, shaped by cultures of emotional suppression and workload constraints, and rarely addressed by interventions with demonstrated efficacy (Phillips et al., 2025). Warning signs include numbness, overidentification, avoidance, and rushing past grief in session. The ethical standards on competence and on personal problems that may interfere with professional work (APA, 2017a, Standards 2.01 and 2.06) apply directly. It is difficult to help a client stay with grief when the clinician has not found ways to stay with their own.

Evidence-Based Assessment and Practice Considerations

STAY informs practice at intake and assessment, within the session, across settings, and in reflective practice and supervision. The considerations below describe what to do, how to do it, and with whom. They are offered as touchpoints to adapt to each client and setting rather than as a fixed sequence.

Grief is difficult to track when no one asks about it. A brief loss history is useful at intake across settings, not only in bereavement referrals, and it is worth revisiting whenever a client's circumstances change. Useful questions include "What losses have you experienced, recent or long ago, that still feel present?" "Has anything changed in your health, relationships, work, or sense of who you are that you haven't had space to talk about?" and "Who or what do you miss?" Asking about loss broadly, rather than only about deaths, gives clients permission to name non-death and disenfranchised losses. For Riley, returning to a loss question when the diagnosis arrived would have signaled that the therapy had room for it.

After asking about loss, the clinician holds one question: Is this normative grief? Figure 1 illustrates this decision point. When grief appears normative, presence is the plan: STAY, psychoeducation, and normalizing grief's waves, with ongoing monitoring. When the answer is uncertain, or when risk is present, the clinician assesses further and treats, consults, or refers. Presence and assessment are not in tension; STAY shapes how assessment is conducted.

Table 2 summarizes distinguishing features. Normative grief comes in waves, positive emotion remains reachable, and self-esteem is generally preserved. Depression tends to be pervasive and flat, and guilt and worthlessness become global. PGD, as defined in the *DSM-5-TR*, involves intense yearning for or preoccupation with the deceased persisting at

least 12 months after the death for adults (6 months for children and adolescents), accompanied by symptoms such as identity disruption, marked disbelief, intense emotional pain, or emotional numbness, causing clinically significant impairment and clearly exceeding the norms of the person's cultural and religious context (American Psychiatric Association, 2022). The cultural criterion is central and often overlooked. Culturally normative mourning can resemble PGD when viewed from outside the culture, and the *DSM-5-TR* locates the reference point in the norms of the client's culture and context rather than the clinician's. Curiosity about how a client learned to mourn supports accurate assessment: "Who taught you how to grieve?" "What would your family normally do with a loss like this?" and "What part of that can't you get to from here?"

Validated measures support this differentiation when they are interpreted within the clinical relationship. The Prolonged Grief-13-Revised (PG-13-R) is a brief self-report measure aligned with *DSM-5-TR* criteria that has demonstrated strong internal consistency and predicted later depression, PTSD, suicidal ideation, and functional impairment (Prigerson et al., 2021). The Traumatic Grief Inventory-Self Report Plus (TGI-SR+) assesses PGD under both *DSM-5-TR* and *ICD-11* criteria and is particularly useful when a loss was sudden or violent (Lenferink et al., 2022). Standardized measures of depression, posttraumatic stress, and suicide risk remain indicated when clinically warranted. Several cautions apply. PGD measures are designed for death-related loss and should not be used to diagnose non-death grief such as Riley's. Scores should be interpreted in light of culture, time since the loss, and proximity to anniversaries (Leaune et al., 2025). Measures work best when introduced collaboratively, framed as a way to understand the client's experience rather than to judge whether their grief is "too much," and reviewed with the client as shared information.

For Alex, the referral question about depression was reasonable. A grief-informed assessment explored whether Alex's low mood was pervasive or came in waves, whether positive emotion remained accessible (time with the children still brought moments of warmth), and whether guilt was specific to the caregiving and the relief or had become global. Alex's presentation was consistent with normative, deeply fatigued grief, and the therapist continued to monitor mood across sessions.

Table 2 *Distinguishing Normative Grief, Major Depression, and Prolonged Grief Disorder*

Feature	Normative grief	Major depression	Prolonged grief disorder
Core experience	Waves of yearning and sadness tied to reminders of the loss	Pervasive low mood or loss of interest across contexts	Intense yearning for or preoccupation with the deceased nearly every day
Positive emotion	Remains reachable; humor and warm memories coexist with pain	Markedly diminished across contexts	Often blocked; marked difficulty engaging in life
Self-concept and guilt	Generally preserved; guilt tends to be specific to the loss	Global worthlessness and guilt	Identity disruption (e.g., feeling part of oneself has died)
Timing	Variable; intensity typically softens, with resurgence around reminders and anniversaries	Most of the day, nearly every day, for at least 2 weeks	At least 12 months after the death for adults; 6 months for children and adolescents
Cultural context	Expression varies widely; judged against the client's own norms	Presentation and idioms of distress vary by culture	Must clearly exceed social, cultural, or religious norms
Assessment supports	Loss history; clinical interview; monitoring over time	Clinical interview; standardized depression measures	PG-13-R; TGI-SR+; clinical interview

Note. Based on American Psychiatric Association (2022), Prigerson et al. (2021), and Lenferink et al. (2022). Conditions can co-occur. Prolonged grief disorder criteria apply to death-related loss; non-death grief is assessed clinically. PG-13-R = Prolonged Grief-13-Revised; TGI-SR+ = Traumatic Grief Inventory-Self Report Plus.

Bring the Stance Into Session

Slow Down

Slowing down means creating space rather than filling it. The clinician first regulates their own nervous system through breath, posture, and tone, so they can attend to the client's experience rather than to their own discomfort. This self-regulation is not only for the clinician's benefit. A regulated, attuned clinician communicates safety through facial expression, tone of voice, and posture, cues that can help downregulate a grieving client's defensive states and create conditions for connection (Geller & Porges, 2014). Silence is honored rather than filled with reflections or reframes, and the clinician notices when they are moving faster than the client (Geller & Greenberg, 2012). A simple question often opens the space: "What do you need right now?" When Alex said, "I feel more tired than sad," the therapist resisted redirecting to sleep hygiene and instead said, "Tired makes a lot of sense after everything you've been carrying. Can we stay with that for a moment?"

Track the Loss

Grief is rarely about just one thing. Tracking the loss means mapping primary, secondary, and hidden losses, including routines, roles, identity, future expectations, relationships, safety, community, and belief. Secondary losses are often where the most significant grief lives. The clinician asks, "What else has changed since then?" and listens for identity language such as "I don't know who I am now" (Neimeyer, 2001). Tracking also attends to cumulative loss across a lifetime and to the client's own culturally grounded understanding of what was lost. It includes losses that are not always counted: a partner the family never acknowledged, someone who died while incarcerated, a relative who died in another country the client could not travel to, or the loss of a homeland, a language, or a version of oneself that existed before assimilation (Doka, 2002). Clinicians are not the experts on what clients carry, and this is especially important for clinicians from majority groups to hold. The task is to ask, and to stop assuming the death is the only thing in the room. Alex and the therapist mapped the parent Alex knew before the illness, years of anticipatory loss, the caregiving role and the purpose it carried, time taken from Alex's own children, and the weight of family expectations. Riley's map included the body Riley had trusted, a planned career path, spontaneity, the experience of being believed by medical providers, and the more confident self that had been emerging in therapy. These are the kinds of living, non-death losses Harris (2020) describes: ongoing, often unacknowledged by others, and in need of language before they can be fully grieved.

Allow Complexity

Grief holds contradiction. Allowing complexity means validating both/and experiences without rushing to resolve them, and resisting subtle pressure toward acceptance, forgiveness, gratitude, or positive reframing. The clinician might say, "Both of those can be true at the same time." For Alex, relief and sorrow, and love for the parent alongside resentment of the illness, were held side by side. For Riley, wanting to return to prior goals and needing to grieve the diagnosis were both honored; positivity as a coping strategy was not challenged, and it was no longer the only response that felt permitted. Allowing complexity also includes honoring continuing bonds, such as rituals or ongoing inner conversations with the deceased that are meaningful within the client's tradition (Klass et al., 1996).

Complexity also lives in how grief is expressed. Martin and Doka (2000) described a continuum between intuitive grieving, which is felt and expressed through emotion, and instrumental grieving, which is processed through thought

and action. Most people blend both. Alex's organizing, paperwork, and quick return to work reflected an instrumental pattern that could be misread as avoidance, while another client's frequent tears could be misread as being stuck. Neither pattern is healthier, and neither belongs to any one gender. Within families, differing styles can create friction when one person's grief looks like doing and another's looks like feeling, and naming the difference often eases it.

Allowing complexity also means setting aside assumptions about how grief should present. Grief is where cultural assumptions surface fastest, and clinicians often do not notice their own. Many of those assumptions come from a majority cultural lens: that grief is private, that it is expressed through tears, that it moves toward letting go, and that it follows a predictable timeline. Speaking to a deceased grandmother every morning is a continuing bond, not denial. Loud, communal wailing is not dysregulation, and composed stoicism is not avoidance. Each of these expressions has been described as pathological by someone unfamiliar with the tradition. A stance of cultural humility asks the clinician to stay curious about what grief means to this client, within this family and community, rather than measuring the client against an internal template (APA, 2017b).

Complexity also includes the context in which a loss lands. No loss arrives by itself; it lands on top of everything else a person is already carrying. For many clients, a background humming sound runs underneath the loss: racism, discrimination, being the only one in the room, collective grief, and bracing for what comes next. The hum works much like the sound machine outside a therapy office door. It runs all day, and while the clinician may know it is there, its effect on the nervous system often becomes noticeable only when it is switched off at the end of the day. For clients living within systems of racism, poverty, ableism, heterosexism, and other forms of oppression, the hum does not switch off, and it was running long before anyone died (Blueford & Adams, 2021). When a loss occurs, it lands on a nervous system that has been working overtime for years. Clinically, the client is carrying the loss event plus the hum, and an assessment focused only on the death captures only part of the picture. Clients may also reach therapy later, after losses have accumulated, with grief braided together with other threads, such as a job that did not come through, a forced move, housing instability, or a life-changing diagnosis. A presentation may look more complicated precisely because the client has carried more, for longer, with less support. Allowing complexity means exploring how these intersecting experiences shape both the grief and the client's access to grief-informed care, and holding the full picture rather than reducing it to a single diagnosis, a single loss, or a single timeline.

Yield to the Moment

Grief does not follow a treatment plan. Yielding means responding to what is needed in this session, with this client, rather than adhering rigidly to a predetermined agenda. It does not mean abandoning structure; it means holding structure lightly. A clinician might say, "We can set the plan aside today. This feels like where we need to be." With Riley, the therapist named the shift directly, collaboratively paused the protocol for several sessions to make room for the loss, and then returned to cognitive and behavioral skills with goals revised to reflect the reality of living with a chronic illness. Moving between grief and skills in this way mirrors the oscillation between loss-oriented and restoration-oriented coping that characterizes adaptive grieving (Stroebe & Schut, 1999). Yielding also asks the clinician to trust that staying present is itself an intervention.

Integrate STAY With Evidence-Based Interventions

Because STAY is a stance, it pairs with evidence-based approaches rather than competing with them. The dual process model supports deliberate alternation between loss-oriented work and restoration-oriented goals, which allowed Alex's therapist to address burnout and work functioning while also making room for grief (Stroebe & Schut, 1999). Meaning-making interventions such as narrative retelling, legacy work, and letter writing support integration (Neimeyer, 2001), and integrative approaches that combine emotional processing with meaning-making offer practical guidance for sequencing this work (Ungureanu & Hall, 2025). Ritual elements, including symbolic acts, remembrance, and culturally

meaningful practices, appear across evidence-informed grief interventions and can be adapted to the client's tradition (Wojtkowiak et al., 2021). When criteria for PGD are met, targeted treatments such as complicated grief treatment have demonstrated efficacy (Shear, 2015), and STAY continues to inform how that treatment is paced and delivered.

Carry the Stance Across Settings and Roles

Because STAY orients rather than prescribes, it is accessible to clinicians and nonclinicians alike. The four movements stay the same across settings; what changes is depth, scope, and language. Table 3 summarizes examples.

The therapy office. In outpatient psychotherapy, STAY informs intake, case conceptualization, pacing, and the timing of evidence-based interventions, as illustrated throughout Alex's and Riley's care. It is compatible with a range of theoretical orientations, including cognitive behavioral, psychodynamic, feminist, humanistic, and systemic approaches. In telepsychology, clinicians can also attend to whether the client has a private space in which grief can safely surface.

Integrated primary care and medical settings. Visits are brief, and grief often surfaces around diagnoses, functional decline, and deaths. Slowing down may mean one unhurried minute; tracking may mean a single question, such as "What has this changed for you?" For Riley, a primary care or specialty clinician who named the diagnosis as a loss, and not only as a treatment plan, might have opened the door to grief earlier.

Long-term care. Residents often live with cumulative losses of home, mobility, independence, privacy, and peers, and families may carry anticipatory and ambiguous grief, particularly when a loved one is living with dementia (Boss, 1999). A resident who repeats "I just want to go home" may be grieving rather than requesting discharge. Staff grief is also common in these settings and frequently goes unrecognized (Phillips et al., 2025). STAY offers interdisciplinary teams a shared language for recognizing grief in care planning, family meetings, and daily care.

The workplace. Grievers may turn first to managers and colleagues rather than clinicians, and may return to work before they feel ready. Alex returned after three days. A manager oriented by STAY might slow down enough to ask how Alex is doing, track what has changed by asking what would help right now, allow that Alex may feel both relieved to be back and depleted, and yield by adjusting deadlines, modifying work modality, or scheduling a check-in. Psychologists who consult with organizations can help leaders build grief literacy into return-to-work practices, bereavement policies that recognize chosen family and non-death losses, and responses to collective losses such as the death of a colleague or organizational change.

Family systems. Families grieve together, and they grieve differently. Psychologists can use STAY to educate families about the variability of grief: styles differ between members, children and adolescents grieve differently than adults rather than less, and relief, anger, and sadness can coexist. For Alex, a family session might help siblings who were not present for daily caregiving understand the anticipatory loss Alex carried, and help Alex's children find language for missing their grandparent. For Riley, psychoeducation with a partner or family members could name the diagnosis as a loss worth grieving rather than a problem to solve.

Schools and educational settings. Students and educators grieve deaths, moves, family changes, and illness, and grief in young people can look like anger, withdrawal, or intense focus. Riley's faculty, advisors, and disability services office were positioned to respond to the loss of a planned academic path with flexibility rather than judgment.

Across these settings, the stance is scaled to role and scope of practice. Nonclinical helpers are not asked to provide treatment. They are invited to lean toward grief rather than away from it, and to know when and how to connect someone with additional support.

Table 3 *Applying the STAY Stance Across Professional Settings*

Setting	Slow Down	Track the Loss	Allow Complexity	Yield to the Moment
Therapy office	Regulate first; let silence breathe	Map primary, secondary, and hidden losses	Hold relief and sorrow; honor differing grief styles	Pause the protocol; revise goals collaboratively
Primary care and medical	One unhurried minute at diagnosis or decline	"What has this changed for you?"	Hold hope and grief about the body together	Make room for the grief moment before the plan
Long-term care	Pause the task pace; notice the person	Home, mobility, peers, privacy, and roles	Grief, anger, and relief can coexist for residents and families	Hear "I want to go home" as possible grief
Workplace	Resist rushing back to business as usual	"What would help right now?"	Relief at returning and depletion can coexist	Adjust deadlines; offer check-ins
Family systems	Slow family conversations about the loss	Each member's losses, including children's	Normalize differing grief styles within the family	Let family rituals and timing lead
Schools and education	Pause before academic or disciplinary consequences	Deaths, moves, illness, and family changes	Grief can look like anger, withdrawal, or intense focus	Offer flexibility in deadlines and participation

Note. Examples are illustrative rather than prescriptive. The four movements remain consistent across settings, while depth and language are scaled to role and scope of practice. Nonclinical helpers apply the stance within their role and connect people with additional support when needed.

Conclusions

Alex and Riley arrived with different presenting concerns, at different points in treatment, carrying losses that looked nothing alike. What they shared was grief that had not been named, and therapists who felt a legitimate pull toward structure and symptom reduction.

For Alex, the first lesson is that burnout and grief can coexist, and treating one does not require overlooking the other. Asking about loss and differentiating normative grief from depression kept the therapist from either missing the grief or pathologizing it. Tracking revealed that Alex had been grieving for years before the death, and that the loss of the caregiving role, not only the loss of the parent, was driving much of the depletion. Allowing complexity made room for relief without shame, and holding Alex's family and cultural values alongside the grief helped the therapist understand caregiving as an expression of love and duty rather than a failure to set boundaries. Yielding to the moment let sessions oscillate between grief and restoration: planning a realistic workload one week, and sitting with photographs of the parent before the illness the next. As the grief was acknowledged, the exhaustion began to ease, and the three days of bereavement leave became part of a broader conversation about what support Alex still needed, at work and within the family.

For Riley, the central lesson is that grief can arrive in the middle of treatment for something else, and that rising symptom scores may signal a new loss rather than a setback. Yielding to the moment did not mean abandoning an effective protocol; it meant pausing it, naming the loss, and returning with goals that reflected Riley's changed life. Allowing complexity meant holding Riley's grief together with the medical dismissal that preceded the diagnosis; acknowledging that history and validating Riley's experience of their body strengthened the therapeutic alliance. Tracking gave Riley language for what had changed, and "I don't recognize myself anymore" became a starting point for meaning reconstruction rather than a symptom to reduce.

Several principles apply across both cases. Grief often presents under another name, so it helps to ask about loss directly. Assessment and presence work together rather than in competition. Structured treatment remains useful when clinicians are willing to adjust it as grief emerges. Culture, context, and systemic conditions shape how grief is expressed and what is considered normative, so understanding the client's frame of reference comes before drawing conclusions. Because STAY is a stance rather than a protocol, the same four movements can guide therapists, physicians, long-term care staff, managers, teachers, and family members. Finally, the clinician's own capacity to STAY with grief is part of the intervention. Grief is not a detour from the work of therapy; it is often the doorway into it.

Key Clinical Considerations

- Ask about loss, not only death, at intake and whenever a client's circumstances change;
- Differentiate before diagnosing: normative grief comes in waves, depression is pervasive, and prolonged grief disorder requires persistence, impairment, and departure from cultural norms.
- Use STAY as an orienting stance across settings, alongside evidence-based treatments.
- Hold structure lightly; pausing a protocol to make room for grief is responsive care, not a departure from it.
- Let go of assumptions about how grief should look; practice cultural humility, consider the systemic load clients carry, and tend to your own grief.

Declarations

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No. The author has no other financial or non-financial interests that might be perceived to influence the content of this paper.

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Author Contribution

H.L.T. conceptualized the STAY framework and the manuscript, developed the clinical vignettes, conducted the literature review, wrote and revised the manuscript, and prepared Tables 1–3 and Figure 1. H.L.T. reviewed and approved the final manuscript and takes full responsibility for its content.

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Figures

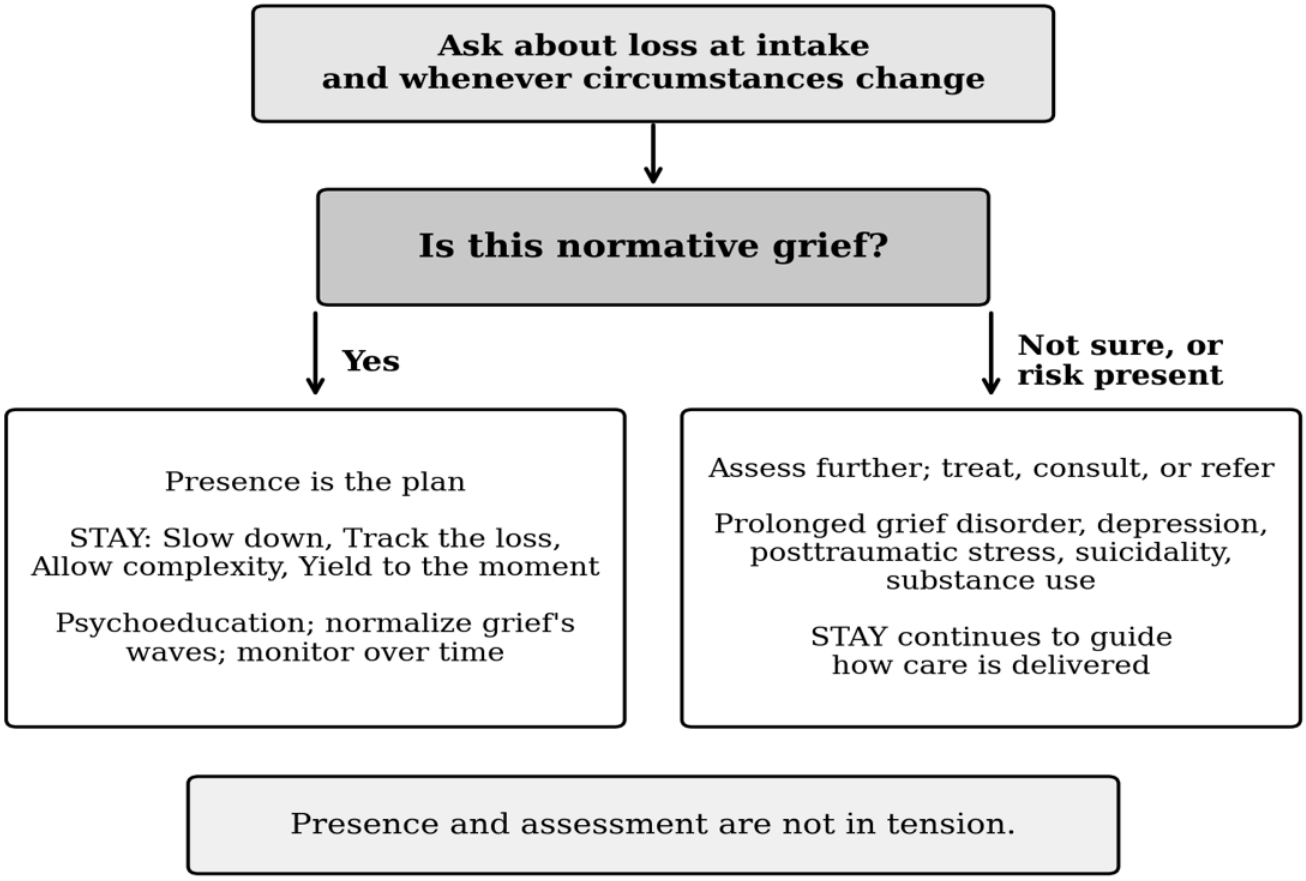


Figure 1

Grief-Informed Decision Pathway: Assessment and Presence

Note. Normative grief warrants presence, psychoeducation, and monitoring. Uncertainty or risk warrants further assessment, treatment, consultation, or referral, with the STAY stance continuing to shape how care is delivered.