

Climate Anxiety and Ecological Grief: Distress, Impairment, and Care

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Narrative Clinical Review

Abstract—Climate anxiety and ecological grief arise in response to unfolding threats and losses; their presence does not by itself establish a psychiatric disorder. This narrative clinical review examines literature available through 30 August 2022 and offers a framework for distinguishing proportionate concern, constructive worry, grief, trauma-related responses, and disabling anxiety or depression. Distress may follow direct exposure to fire, flood, heat, drought, displacement, or livelihood loss, or arise through anticipated futures, repeated information, political inaction, moral conflict, and damage to a valued place or species. Assessment therefore requires two forms of realism at once: external danger must not be minimized, and impairment, suicidality, sleep disruption, compulsive information seeking, avoidance, and loss of function must not be overlooked. Evidence for climate-specific psychotherapy was limited at the cutoff. Clinicians should use established treatments for diagnosable conditions while adapting formulation to environmental context, culture, age, inequality, and collective responsibility. Useful work may include emotional differentiation, recognition of grief, calibrated media boundaries, restoration of daily function, values-guided action, relational support, and tolerance of uncertainty without false reassurance. Action may strengthen agency, but it is neither a prescription nor proof of recovery, and institutional responsibility cannot be transferred to distressed individuals. A clinically appropriate response acknowledges the basis of the distress, assesses its effects on functioning and safety, and helps the person remain engaged with life while uncertainty and loss continue.

Index Terms—climate anxiety, eco-anxiety, ecological grief, solastalgia, psychotherapy, climate communication

I. INTRODUCTION

Anxiety usually raises the question of whether danger is being overestimated. Climate anxiety complicates that

question because the danger is real and its distribution is unequal. Some people are already losing homes, livelihoods, land, health, and cultural continuity; others meet an anticipated future through science, news, school, activism, or conversation. Reducing the response to distorted thinking misunderstands both the patient and the world; treating all distress as healthy can miss severe impairment.

The language has expanded quickly: climate anxiety, eco-anxiety, ecological grief, solastalgia, climate worry, eco-anger, and despair. These terms overlap but are not interchangeable. Pihkala's analysis shows that eco-anxiety has been used across disciplines for a range of emotional and existential responses (Pihkala, 2020). Ojala and colleagues likewise describe anxiety, worry, and grief as often normal and potentially constructive, while stressing their varied cultural and place-based forms (Ojala et al., 2021). Diagnostic precision should not be simulated where conceptual precision is still developing.

Climate-related mental-health pathways include acute events, gradual environmental change, social and economic disruption, displacement, conflict, and the overarching knowledge of planetary risk (Berry et al., 2010; Palinkas & Wong, 2020). The same person may experience several pathways at once. A farmer facing drought, a young person anticipating an unstable future, and an urban resident repeatedly viewing wildfire footage may all say they are anxious about climate change, but assessment and care should not collapse their situations into one syndrome.

The central clinical distinction is functional rather than ideological. Is the emotion helping the person register threat, grieve, choose, connect, and act, or has it become rigid, consuming, avoidant, despairing, or unsafe? That question must be asked alongside actual exposure, resources, power, and responsibility. The aim of psychotherapy is not to make a patient comfortable with preventable harm. It is to restore enough psychological and interpersonal freedom to think, mourn, participate, rest, and live without denying reality.

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II. SCOPE AND REVIEW METHOD

This narrative clinical review considered literature publicly available through 30 August 2022, one month before the issue date. Searches prioritized systematic and scoping reviews, major scientific and public-health reports, conceptual work, measurement studies, population surveys, and empirical research on worry, grief, hope, action, and mental-health pathways. Online-first publication dates governed eligibility. No quantitative synthesis was undertaken, and recommendations are proportional to the small intervention literature available by the cutoff.

The broader evidence is stronger for mental-health effects of acute disasters, heat, displacement, and socioeconomic disruption than for climate anxiety as a distinct clinical construct. Reviews repeatedly identify methodological heterogeneity, cross-sectional designs, self-report outcomes, inconsistent terminology, and geographical bias (Charlson et al., 2021; Hwong et al., 2022). Associations between climate variables and mental-health outcomes do not establish the mechanism in an individual patient, and an individual's fear does not require epidemiological proof before it deserves careful attention.

The scientific context was taken from the Intergovernmental Panel on Climate Change's 2022 assessment of impacts, adaptation, and vulnerability, which documents observed and projected risks to health, livelihoods, displacement, ecosystems, and communities (Intergovernmental Panel on Climate Change, 2022). The World Health Organization's 2022 policy brief frames mental health as a priority within climate action and calls for integration across services and policy (World Health Organization, 2022). These reports support realism about threat; they do not turn every emotional response into pathology.

The review addresses adults and young people at a conceptual level but does not offer a child-treatment protocol. Culture, place, Indigenous knowledge, occupation, disability, poverty, migration, and political conditions can alter both exposure and meaning. Recommendations concern assessment and communication, not individualized medical advice. No patient cases or quotations are included. Earlier JPPC writing on anxiety and communication is considered only as an author-developed interpretive perspective and not as empirical evidence for climate-specific treatment (Haverkamp, 2017).

III. A LANGUAGE FOR DISTINCT EXPERIENCES

Climate anxiety is often used for apprehension, fear, or impaired functioning connected with climate change. Eco-anxiety can be broader, encompassing ecological degradation beyond climate. Ecological grief concerns loss or anticipated loss of species, ecosystems, landscapes, ways of life, or future possibilities. Solastalgia names place-based distress

experienced while a familiar home environment changes around the person, rather than nostalgia for a place left behind (Albrecht et al., 2007). These distinctions can help conversation without becoming diagnoses.

Measurement has sharpened some questions and introduced others. Clayton and Karazsia developed a Climate Change Anxiety Scale with cognitive-emotional and functional-impairment dimensions (Clayton & Karazsia, 2020). The Hogg Eco-Anxiety Scale proposed affective, ruminative, behavioral, and personal-impact domains (Hogg et al., 2021). A German validation could not simply reproduce the original Climate Anxiety Scale structure and suggested that some items captured broad climate-related impairment rather than anxiety specifically (Wullenkord et al., 2021). Scores therefore require interpretation, not automatic clinical thresholds.

A scoping review found only nine eligible studies and considerable variation in how eco-anxiety was defined and operationalized (Coffey et al., 2021). The terminology was more mature in public conversation than in clinical trials. Clinicians should ask what the patient's chosen word means. 'Climate anxiety' might refer to panic after a flood warning, dread about having children, guilt about consumption, grief for a damaged landscape, anger at government, or an existing anxiety disorder attaching to climate content.

Emotion words also carry social meaning. Calling anger anxiety can make a political response seem private; calling grief depression can imply that a bond with place was excessive; calling all worry rational can obscure compulsive checking. Emotional differentiation is not semantic fussiness. It identifies action tendencies, losses, and needs. Naming sadness, fear, guilt, anger, shame, helplessness, love, or responsibility separately often creates more room than treating them as one undifferentiated climate feeling.

Table 1. Related climate-emotion terms and their clinical use

Term	Primary referent	Useful clinical question	Common error
Climate worry or anxiety	Anticipated climate threat and its consequences	Does concern support preparation or consume functioning?	Assuming realistic content cannot become disabling
Eco-anxiety	Wider ecological threat or degradation	Which losses, values, and uncertainties are present?	Treating a broad family of emotions as one disorder
Ecological grief	Actual or anticipated ecological loss	What bond, place, species, or future is being mourned?	Pathologizing grief because the loss is nonhuman or collective
Solastalgia	Distress as home changes while one remains there	How have identity, safety, livelihood, and belonging changed?	Using the term without attention to power and dispossession

Term	Primary referent	Useful clinical question	Common error
Eco-anger	Perceived wrongdoing, obstruction, or injustice	Does anger organize agency, conflict, exhaustion, or risk?	Converting political anger into individual anxiety

IV. RATIONAL CONCERN, DISTRESS, AND DISORDER

The content of a fear and the form of an anxiety response are different questions. A realistic threat can be met with flexible concern, repeated but purposeful worry, or disabling anxiety. Clayton argues that climate anxiety may be adaptive or maladaptive and warns that an individual mental-health focus must not displace societal action (Clayton, 2020). Clinically, rationality of concern does not immunize a person against insomnia, panic, depression, obsessive checking, substance use, or suicidal despair.

Verplanken and colleagues found that habitual global-warming worry was associated with pro-environmental identity and behavior and, for many participants, appeared constructive rather than simply pathological (Verplanken et al., 2020). The result cautions against equating frequency with disorder. Recurrent thought can help a person monitor a significant problem. It becomes clinically concerning when it is uncontrollable, repetitive without new information, disproportionate to the decisions available, or accompanied by marked distress and functional loss.

External danger must remain in the formulation. Advice to challenge catastrophic thinking is poorly chosen if it asks a person to deny documented risk, current smoke, repeated flooding, or threatened livelihood. Cognitive work can instead examine claims that exceed the evidence, such as certainty that no meaningful future remains, personal responsibility for stopping a global process, or the belief that resting constitutes betrayal. Accuracy includes both the gravity of climate change and the limits of one person's knowledge and control.

A diagnosis, when present, should be based on established criteria and the whole presentation. Climate content can occur within generalized anxiety disorder, major depression, post-traumatic stress disorder, obsessive-compulsive disorder, panic disorder, adjustment disorder, grief, or no disorder. The label should explain something about course, impairment, and treatment; it should not merely replace 'about climate change' with a medical term. Formulation can hold diagnosis and realistic context at the same time.

V. PATHWAYS FROM CLIMATE CHANGE TO MENTAL HEALTH

Direct pathways include injury, bereavement, exposure to wildfire, storm, flood, extreme heat, and threat to life. Acute disasters are associated with post-traumatic stress, depression,

anxiety, substance problems, and complicated recovery, although outcomes vary and most exposed people do not develop a persistent disorder (Goldmann & Galea, 2014). Climate attribution may be complex for a particular event, but clinical care need not wait for perfect attribution when the person has lived through disaster.

Indirect pathways unfold through housing, food and water insecurity, work loss, migration, family conflict, disrupted healthcare, and weakened community networks. Berry and colleagues' causal-pathways framework and later reviews show why a narrow focus on fear misses much of the burden (Berry et al., 2010; Hayes et al., 2018). A person described as climate anxious may primarily need trauma treatment, practical advocacy, income support, medical care, housing, or reconnection with community rather than an intervention aimed at beliefs.

Gradual changes can be harder to narrate than discrete events. Drought, coastal erosion, heat, seasonal change, species decline, and repeated smaller losses may produce chronic vigilance and grief without a clear before-and-after story. Palinkas and Wong distinguish acute, subacute, and existential impacts, each with different temporal and service implications (Palinkas & Wong, 2020). Assessment should build a timeline of environmental change, exposure, symptoms, losses, moves, and available support.

Information is another pathway. News, scientific reports, social media, activism, school, and conversations can bring distant or future harms into daily awareness. Repeated exposure may educate, mobilize, overwhelm, or become compulsive. The clinician asks what information is sought, how often, from which sources, with what emotional and behavioral aftermath, and whether new knowledge is being gained. Limiting exposure is not denial when it restores the ability to act; unlimited exposure is not moral seriousness when it produces paralysis.

VI. ECOLOGICAL GRIEF, PLACE, AND CONTINUING BONDS

Ecological grief recognizes that people can mourn more than human death. Cunsolo and Ellis describe grief following actual or anticipated losses of species, ecosystems, landscapes, and environmental knowledge, drawing on research in Northern Canada and the Australian Wheatbelt (Cunsolo & Ellis, 2018). The loss can involve livelihood, identity, ancestry, sensory familiarity, and a future expected to continue. It may be disenfranchised because others do not recognize an ecosystem or season as something one can grieve.

Grief should not be measured only by its disappearance. A damaged place may remain loved, and a species loss cannot be cognitively corrected. Therapy can help the person describe what has been lost, find witnesses, preserve memory and

practice, and decide how the relationship continues through care, restoration, teaching, art, ritual, or advocacy. These are possibilities rather than prescribed stages. Some losses remain unresolved because the damaging process continues.

Solastalgia adds the experience of environmental change while remaining at home (Albrecht et al., 2007). The concept is clinically useful when it directs attention to place, but it can become superficial if detached from land rights, extraction, livelihood, or political power. The therapist should ask who controlled the change, who benefited, what alternatives existed, and whose account is treated as credible. Distress may be a response to dispossession as much as to altered scenery.

Continuing bonds with place can support recovery without requiring optimism. Visiting a changed landscape, participating in restoration, recording ecological knowledge, or maintaining community practice may be meaningful; for another person, these acts may intensify pain or be physically impossible. The therapist follows the bond rather than imposing nature contact as a universal remedy. Grief becomes more bearable through recognition and relationship, not through pressure to convert every loss into growth.

VII. YOUNG PEOPLE AND INTERGENERATIONAL COMMUNICATION

Young people often encounter climate change as a future they will inhabit but did not design. A survey of 10,000 people aged 16 to 25 across ten countries found widespread worry and associations between distress, daily functioning, and perceived inadequate government response (Hickman et al., 2021). The cross-sectional design does not establish diagnosis or causation, and the online sample is not every young person. It does show that political trust and perceived betrayal belong in the emotional context.

A social-ecological review emphasizes that climate anxiety in children and adolescents is shaped by family, peers, school, community, media, government, culture, and physical environment, not simply individual vulnerability (Crandon et al., 2022). Clinical assessment should therefore ask what adults communicate. Reassurance that dismisses evidence can undermine trust; catastrophic certainty can burden a child with adult despair. Developmentally appropriate honesty includes what is known, what is uncertain, what adults are doing, and what the young person is not responsible for carrying alone.

Parents and clinicians may disagree about activism, information exposure, or whether the concern is excessive. The young person's functioning and voice should remain central. Avoidance of school, insomnia, self-harm, panic, and hopelessness require direct assessment, while interest in climate science or participation in collective action should not be treated as symptoms. A family conversation can separate shared values from different coping styles and establish times for information, rest, ordinary life, and action.

Developmental assessment also asks who is carrying whose emotion. A young person may be frightened by climate information, by a caregiver's despair, by conflict between adults, or by being treated as the household's moral authority. Conversely, adults may dismiss a well-informed concern because its intensity makes them uncomfortable. The clinician can meet family members together and separately where appropriate, clarify what the young person knows, and restore adult responsibility for safety and practical decisions. Useful containment does not require secrecy or false certainty. It provides predictable opportunities for questions, limits exposure that has become dysregulating, and protects education, friendship, play, and sleep as parts of development rather than distractions from citizenship (Crandon et al., 2022; Ojala, 2013).

Hope is not supplied by insisting that everything will be fine. Ojala found that constructive hope among young people can coexist with acknowledgment of seriousness and may support engagement, whereas denial-based hope avoids the problem (Ojala, 2012). Coping research likewise distinguishes strategies associated with well-being and environmental involvement from distancing or helplessness (Ojala, 2013). Adults earn credibility by tolerating the child's questions and by accepting responsibility proportionate to their role.

VIII. ASSESSMENT: TWO FORMS OF REALISM

Assessment begins with the event and environment, not only the symptom list. What has happened directly? What losses are occurring or anticipated? Is there heat exposure, smoke, displacement, financial strain, unsafe housing, disrupted medication, or caregiving burden? Which information is verified, uncertain, or repeatedly sought? The clinician then asks about sleep, concentration, mood, bodily arousal, avoidance, checking, substance use, relationships, work or study, pleasure, and risk.

The second realism concerns internal function. How controllable is the worry? Does it produce a decision, preparation, connection, or action, or circle without new information? Can attention move to food, work, friendship, creativity, or rest? Does the person still experience a future, even an altered one? Climate-specific measures may structure discussion, but psychometric uncertainty and inconsistent factor structures argue against treating a score as diagnosis (Clayton & Karazsia, 2020; Wullenkord et al., 2021).

A parallel timeline can reveal several processes. Symptoms may begin after a disaster, after a media event, during occupational loss, with an independent depressive episode, or alongside obsessive-compulsive rituals. A person with earlier trauma may experience climate events as renewed threat; another may have no prior disorder and be grieving visible ecological change. The formulation should not force one causal story when several pathways interact.

Protective factors are concrete rather than celebratory. They include safe housing, healthcare, income, social trust, community knowledge, cultural continuity, practical preparedness, reliable information, sleep, supportive relationships, and meaningful roles. Privilege may protect some domains while creating guilt or distance from those already harmed. The assessment asks what is available and usable, not whether the patient possesses an abstract quality called resilience.

Assessment should be repeated because both environmental exposure and the person's response can change. A week of poor sleep during a nearby fire differs from six months of pervasive anhedonia, although one may develop into the other. At follow-up, ask what has changed in exposure, information use, family conflict, practical options, physical health, and future orientation.

Functional markers should be recorded in the patient's own terms—for example, attending classes, caring for children, completing paid work, meeting friends, or taking a planned day away from advocacy. These markers make improvement observable without requiring reduced concern, and they may reveal deterioration that an articulate political account obscures.

Diagnostic reasoning remains conventional: consider depressive, anxiety, trauma-related, obsessive-compulsive, substance-related, and sleep disorders, as well as medication effects and the medical consequences of heat or smoke. A climate theme does not establish a climate cause, and a conventional diagnosis does not exhaust the meaning of the distress. When a measure is used, explain what it can and cannot show, interpret change alongside exposure and function, and avoid presenting an uncertain cutoff as a verdict. Revise the formulation as environmental, clinical, and social evidence changes.

Table 2. A dual-reality climate-distress assessment

Domain	External-reality inquiry	Clinical-function inquiry
Exposure and loss	Events, heat, smoke, housing, livelihood, land, species, displacement	Trauma symptoms, grief, bodily health, avoidance, daily safety
Anticipation	Credible local and global risks; uncertainty; time horizon	Worry control, catastrophic certainty, planning, paralysis, future orientation
Information	Sources, frequency, accuracy, occupational or activist need	Compulsive checking, arousal, sleep, concentration, ability to disengage
Action and responsibility	Available choices, institutional duties, collective routes	Agency, guilt, perfectionism, overextension, conflict, burnout
Resources and inequality	Housing, income, care, community, political power, cultural ties	Support, isolation, prior disorder, substance use, suicide risk

IX. THE CLINICIAN'S STANCE: VALIDATION WITHOUT COLLUSION

Validation begins by recognizing that climate threat and ecological loss are real. It does not require agreeing with every prediction, accepting that catastrophe is certain, or endorsing harmful action. The therapist can say that the concern makes sense and then ask what form it has taken. This separates the legitimacy of the subject from the consequences of the response. Patients should not have to exaggerate impairment to be taken seriously or deny reality to qualify for anxiety treatment.

False reassurance is fragile. Claims that technology will solve everything, that the patient's locality is safe, or that worry is pointless exceed the clinician's knowledge and may repeat social invalidation. A more credible response distinguishes evidence, uncertainty, and control. The therapist can help the patient tolerate that some outcomes are unknown while identifying decisions that can be made now. Hope becomes a practice of engagement, not a forecast guaranteed by authority.

Collusion can take a pessimistic form as well. A therapist may share the concern and inadvertently confirm that ordinary pleasure, parenting, travel, work, or rest is morally suspect. Shared values do not remove the clinician's duty to assess depression, obsession, trauma, and risk. The patient's claim that no personal future is permissible should be explored with the same care as any global conclusion that organizes self-neglect.

Communication-focused work may attend to how messages from science, media, family, politics, and the patient's own internal dialogue acquire meaning. Earlier JPPC writing proposes that anxiety can be understood partly through internal and interpersonal communication (Haverkamp, 2017). In climate work this remains an author-developed lens, not a validated climate treatment. Its value depends on whether examining message, interpretation, and response clarifies the patient's choices without displacing structural reality.

Five responses that preserve reality and clinical inquiry

- Name the threat or loss without deciding in advance whether the response is disordered.
- Separate what is documented, uncertain, anticipated, and personally controllable.
- Ask what worry, grief, anger, or guilt does next in the person's life.
- Assess sleep, function, substance use, self-harm, and suicide directly.
- Offer treatment and practical support without assigning the patient responsibility for solving climate change.

X. PSYCHOTHERAPY WHEN THE EVIDENCE IS INDIRECT

By August 2022 there was no mature trial literature establishing a climate-specific psychotherapy. Reviews mapped concepts, correlates, and research gaps more often than interventions (Coffey et al., 2021; Hwong et al., 2022). Clinicians should therefore avoid branding ordinary supportive, cognitive-behavioral, grief, trauma-focused, or acceptance-based work as proven eco-anxiety treatment. They can apply established methods to the diagnosed condition and stated problem while adapting formulation to a realistic environmental threat.

For worry, treatment can distinguish solvable problems from uncertain scenarios, reduce repetitive checking, restore sleep and attention, and test beliefs about personal responsibility. Cognitive restructuring should target overgeneralization, omnipotent guilt, and certainty beyond evidence rather than the existence of climate risk. Behavioral work may reintroduce valued activities abandoned through despair. An ordinary meal, friendship, or creative project is not a denial of crisis; it can be part of the capacity required for sustained engagement.

For trauma, evidence-based trauma treatment remains relevant after disasters, with attention to continuing danger, displacement, and practical needs. Exposure or memory processing should not be undertaken as if the threat has fully ended when the person remains unsafe. For grief, therapy may provide recognition, narrative, ritual, continuing bonds, and community connection. For depression, loss of energy and future orientation may need direct treatment even when pessimistic thoughts refer to real environmental conditions.

Because the climate-specific intervention evidence was indirect, treatment goals should be defined with unusual precision. Patient and therapist can agree whether the immediate aim is sleep, reduced panic, trauma processing, less compulsive checking, restored study, tolerable family conversation, grief support, or sustainable participation. They then monitor that outcome without using diminished concern as the default sign of recovery. If a media boundary improves sleep but increases isolation, or activism increases connection while intensifying risk, the formulation changes. This disciplined feedback guards against two opposite forms of drift: repackaging a familiar therapy as a proven climate treatment and offering sympathetic conversation without evaluating whether the patient's life is becoming more workable (Coffey et al., 2021; Hwong et al., 2022).

Emotion differentiation helps select action. Fear may call for safety and preparation; grief for witnessing and mourning; anger for boundary or collective response; guilt for an examination of responsibility and repair; shame for reconnection with a broader identity. These are clinical hypotheses, not fixed prescriptions. The patient's culture and

community may hold different ways of expressing and responding to emotion, and psychotherapy should not replace them with an individual Western script.

XI. ACTION, AGENCY, AND THE RIGHT TO REST

Climate action can restore agency, social connection, and coherence. It can also expose a person to conflict, repeated alarming information, legal risk, organizational strain, and burnout. Stanley and colleagues found that eco-anger, eco-anxiety, and eco-depression related differently to well-being and pro-climate behavior; eco-anger was particularly associated with action in their Australian survey (Stanley et al., 2021). Cross-sectional associations do not establish that activism treats distress or that one emotion should be cultivated.

The therapeutic task is to find action proportionate to values, resources, and role. Possibilities range from household preparation and voting to professional contribution, community organizing, restoration, mutual aid, education, or art. A small action is not prescribed to make the patient feel better, and a large action is not proof of moral adequacy. The person chooses with awareness of impact, limits, and the collective nature of the problem.

Rest can become morally charged. Some patients believe that sleep, pleasure, or stepping away from news constitutes abandonment of threatened people or species. This belief may produce unsustainable cycles of overwork and collapse. Therapy can examine whether exhaustion improves the work, who benefits from limitless availability, and what rhythm allows participation to continue. Boundaries are not indifference when they preserve judgment, relationships, health, and long-term contribution.

Role clarity can make those boundaries concrete. A person may be simultaneously a clinician, organizer, parent, scientist, neighbor, donor, and frightened citizen, with each role implying a different duty. Therapy can map which responsibilities are chosen, assigned, shared, or impossible and identify early signs that one role has colonized the rest of life. Warning signs include secrecy about exhaustion, inability to hand over tasks, contempt for less intensive participation, repeated conflict, and the belief that only personal collapse proves commitment. A sustainable experiment may involve a defined term of service, shared leadership, a communication-free evening, or a planned handover. These are not prescriptions to reduce action; they test whether participation can remain effective without requiring the person's disappearance into it (Hayes et al., 2018; Stanley et al., 2021).

Agency also includes accepting limits. No individual can obtain certainty, prevent every loss, or compensate through perfect consumption for failures of policy and industry. Hayes and colleagues call for coordinated action rooted in active hope and attention to inequity (Hayes et al., 2018).

Psychotherapy can help locate the person's part without making the therapeutic goal adaptation to institutional failure. Anger and grief may remain after function improves because the situation still warrants them.

Table 3. From climate emotion to sustainable participation

Clinical pattern	Possible function	Risk if rigid	A more sustainable experiment
Repeated information seeking	Learning and preparation	Arousal, sleep loss, no new decisions	Use trusted sources at agreed times and record what changes
Individual lifestyle control	Integrity and concrete contribution	Perfectionism, guilt, interpersonal policing	Choose high-value actions and retain proportionate responsibility
Collective action	Agency, solidarity, political influence	Conflict, exposure, burnout, legal or physical risk	Clarify role, boundaries, support, and recovery time
Avoidance or numbing	Short-term relief from overload	Isolation, delayed preparation, depression	Approach one bounded conversation or task with support
Rest and ordinary pleasure	Regulation, relationship, continuity of life	Guilt may lead to self-denial	Treat restoration as part of durable participation, not a reward

XII. COMMUNICATING IN FAMILIES, COMMUNITIES, AND PUBLIC LIFE

Climate communication often fails by offering either alarm without agency or reassurance without credibility. In families, people may differ in knowledge, politics, tolerance of uncertainty, and willingness to act. The clinician can help them describe impact before debating facts: what happens when the subject arises, who pursues, who withdraws, what each person fears, and what decisions actually need to be made. Not every disagreement can be resolved, but communication can become less coercive.

A bounded conversation is often more productive than an attempt to settle the whole climate question. Participants can identify one decision, distinguish facts from forecasts and values, agree how sources will be checked, and take turns describing what the other's position means to them before rebuttal. The therapist should not become a climate adjudicator or use professional authority to reward the view closest to their own. When factual misinformation affects an immediate safety decision, credible public-health or scientific sources can be consulted openly; when the conflict concerns identity, trust, cost, or responsibility, additional data alone may harden the cycle. Communication improves when disagreement is made specific enough that people can retain relationship and agency without pretending that every difference is merely a misunderstanding (Fritze et al., 2008).

Children need truthful information matched to development and a clear account of adult responsibility. Repeatedly asking

a child to educate the family may increase burden. Adults can listen, acknowledge uncertainty, show what they and institutions are doing, and preserve spaces in which the child is not required to discuss climate. Hickman and colleagues' findings on perceived government inaction suggest that reassurance without visible response may be experienced as betrayal (Hickman et al., 2021).

Communities already facing environmental harm may possess knowledge, practices, and mutual support that clinical services overlook. Professionals should ask what local language is used for the experience and which responses are trusted. Climate communication imported from affluent settings can individualize a problem that is lived through land, work, colonial history, or public neglect. Listening is not a preliminary courtesy; it changes the formulation and the range of legitimate interventions.

Public messages should not manufacture terror to motivate behavior or deny uncertainty to avoid panic. Fritze and colleagues connected mental-health promotion with narratives that acknowledge danger while sustaining informed collective action (Fritze et al., 2008). Clinicians can contribute by explaining normal emotional responses, signs of impairment, and routes to support. They should avoid presenting psychotherapy as the solution to a political and ecological crisis or using clinical authority to settle contested policy beyond their competence.

XIII. INEQUALITY, CULTURE, AND STRUCTURAL RESPONSIBILITY

Climate harms are distributed through existing social conditions. Exposure, housing, work, healthcare, mobility, political power, and the ability to recover differ sharply. Reviews emphasize disproportionate effects among marginalized communities and the need to connect mental-health response with mitigation, adaptation, and justice (Bourque & Cunsolo Willox, 2014; World Health Organization, 2022). A formulation that locates distress solely in individual coping can reproduce the very inequity it claims to treat.

Place and culture shape what loss means. Damage to land may threaten identity, food, language, spirituality, kinship, and knowledge simultaneously. Ecological grief literature emerged partly through work with Inuit communities and Australian farmers, reminding clinicians that attachment to environment is not an optional wellness preference (Cunsolo & Ellis, 2018). Cultural consultation and community leadership may be more important than importing a standardized anxiety vocabulary.

Privilege also deserves nuanced discussion. A patient with material security may feel guilt about consumption or comparative safety. Guilt can support responsibility when linked to a specific, reparative action; global self-condemnation may become paralyzing and self-centered. The

therapist can help distinguish accountability from imagined total control. The aim is not absolution but an honest relation between capacity, benefit, harm, and action.

Institutions must not prescribe resilience while leaving hazards unchanged. Health services can reduce their own emissions, plan for climate events, protect medication and care continuity, support staff, and advocate for public-health measures. The IPCC's assessment places adaptation within social systems and governance, not only individual psychology (Intergovernmental Panel on Climate Change, 2022). Clinical care is one layer of response. It should connect patients with practical and collective resources where possible and name when the required remedy lies outside therapy.

XIV. RISK, SAFETY, AND WHEN DISTRESS IS DISABLING

Risk assessment should be direct when climate distress includes hopelessness, self-harm, suicidality, substance use, severe insomnia, inability to eat, reckless action, or neglect of medical care. The clinician asks whether the person wants to die, sees death as inevitable, believes having a future is morally wrong, or has made plans. Climate content can make suicidality sound philosophical; it remains a clinical risk requiring ordinary careful assessment, safety planning, and urgent intervention when indicated.

After disasters, immediate needs may include shelter, medical treatment, medication replacement, contact with family, legal assistance, and practical stabilization. Psychological first responses should not force detailed emotional processing while basic safety is absent. Cianconi and colleagues' descriptive review maps mental-health effects across multiple climate exposures but also demonstrates the breadth and variability of outcomes (Cianconi et al., 2020). Services should expect distress without presuming that everyone requires formal therapy.

Activism can involve physical danger, arrest, conflict, harassment, and traumatic exposure. The therapist does not decide political tactics, but can assess consent, coercion, preparation, substance use, sleep, and the person's capacity to weigh risk. Likewise, a wish to relocate, avoid pregnancy, change career, or reduce consumption should not be interpreted automatically as anxiety-driven. Decisions are examined for information, values, reversibility, constraints, and whether acute symptoms have narrowed the field.

Medication or diagnosis may be appropriate for a co-occurring condition, but neither should communicate that climate concern itself is an illness. Treatment response can be monitored across symptoms and function while the person's values remain intact. A patient can sleep better, return to work, and remain angry or grieving. Clinical improvement is not ideological conversion; it is greater capacity to live and choose under difficult conditions.

XV. LIMITATIONS

The field was developing rapidly at the cutoff, and this narrative review cannot provide prevalence estimates or a validated treatment algorithm. Climate-anxiety studies used different definitions, samples, measures, and outcomes. The Hogg and Clayton-Karazsia scales offer useful structure but had limited cross-cultural and longitudinal evidence by August 2022 (Clayton & Karazsia, 2020; Hogg et al., 2021). A measured construct should not be treated as a settled disorder.

Much evidence was cross-sectional and drawn from online or Western samples. The large youth survey was geographically broad but still cannot establish causality, clinical diagnosis, or within-country representativeness (Hickman et al., 2021). Scoping reviews found gaps in large-scale causal methods, intervention studies, low-resource settings, and linkage between environmental and clinical data (Charlson et al., 2021; Hwong et al., 2022). People most exposed may be least represented in academic research.

Clinical recommendations are consequently extrapolated from established work on anxiety, trauma, grief, depression, health communication, and community response. The extrapolation is reasonable when its limits remain visible. It would be premature to claim that values work, media boundaries, activism, nature contact, or a particular psychotherapy reliably reduces climate distress. Each can help some people and harm or burden others depending on context.

Research should distinguish emotion from impairment, direct from indirect exposure, climate-specific from general psychopathology, and individual from structural intervention. Longitudinal studies should examine transitions between concern, action, exhaustion, grief, and recovery. Trials should report adverse effects and avoid outcomes that define reduced concern as improvement. Co-designed work with young people, Indigenous communities, frontline workers, displaced people, and low- and middle-income settings is essential.

XVI. CONCLUSION

Climate anxiety and ecological grief are intelligible responses to real danger, change, and loss. They are not diagnoses merely because they are painful, and they are not harmless merely because their object is real. Clinical reasoning must hold external evidence and internal function together: what is happening in the world, what has happened to this person and community, and what the response now permits or prevents.

Assessment differentiates fear, worry, grief, anger, guilt, trauma, and depression; asks about exposure, inequality, culture, place, information, action, sleep, functioning, and safety; and uses diagnosis only when it improves care. Psychotherapy can provide witnessing, emotional precision, evidence-based treatment of co-occurring disorders,

restoration of daily life, sustainable agency, and communication that tolerates uncertainty. It cannot promise safety from climate change or transfer institutional responsibility to the patient.

The central clinical outcome is reality-based agency: the capacity to remain connected to people, place, values, and a livable present while responding honestly to threatened futures. Concern and grief may remain. Treatment succeeds when the person has more freedom to mourn, decide, rest, prepare, participate, and seek collective change without being consumed by a burden no individual can carry alone.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

XVIII. REFERENCES

- Albrecht, G., Sartore, G.-M., Connor, L., Higginbotham, N., Freeman, S., Kelly, B., Stain, H., Tonna, A., & Pollard, G. (2007). Solastalgia: The distress caused by environmental change. *Australasian Psychiatry*, 15(Suppl. 1), S95-S98. <https://doi.org/10.1080/10398560701701288>
- Berry, H. L., Bowen, K., & Kjellstrom, T. (2010). Climate change and mental health: A causal pathways framework. *International Journal of Public Health*, 55(2), 123-132. <https://doi.org/10.1007/s00038-009-0112-0>
- Bourque, F., & Cunsolo Willox, A. (2014). Climate change: The next challenge for public mental health? *International Review of Psychiatry*, 26(4), 415-422. <https://doi.org/10.3109/09540261.2014.925851>
- Charlson, F., Ali, S., Benmarhnia, T., Pearl, M., Massazza, A., Augustinavicius, J., & Scott, J. G. (2021). Climate change and mental health: A scoping review. *International Journal of Environmental Research and Public Health*, 18(9), 4486. <https://doi.org/10.3390/ijerph18094486>
- Cianconi, P., Betrò, S., & Janiri, L. (2020). The impact of climate change on mental health: A systematic descriptive review. *Frontiers in Psychiatry*, 11, 74. <https://doi.org/10.3389/fpsy.2020.00074>
- Clayton, S. (2020). Climate anxiety: Psychological responses to climate change. *Journal of Anxiety Disorders*, 74, 102263. <https://doi.org/10.1016/j.janxdis.2020.102263>
- Clayton, S., & Karazsia, B. T. (2020). Development and validation of a measure of climate change anxiety. *Journal of Environmental Psychology*, 69, 101434. <https://doi.org/10.1016/j.jenvp.2020.101434>
- Coffey, Y., Bhullar, N., Durkin, J., Islam, M. S., & Usher, K. (2021). Understanding eco-anxiety: A systematic scoping review of current literature and identified knowledge gaps. *The Journal of Climate Change and Health*, 3, 100047. <https://doi.org/10.1016/j.joclim.2021.100047>
- Crandon, T. J., Scott, J. G., Charlson, F. J., & Thomas, H. J. (2022). A social-ecological perspective on climate anxiety in children and adolescents. *Nature Climate Change*, 12, 123-131. <https://doi.org/10.1038/s41558-021-01251-y>
- Cunsolo, A., & Ellis, N. R. (2018). Ecological grief as a mental health response to climate change-related loss. *Nature Climate Change*, 8(4), 275-281. <https://doi.org/10.1038/s41558-018-0092-2>
- Fritze, J. G., Blashki, G. A., Burke, S., & Wiseman, J. (2008). Hope, despair and transformation: Climate change and the promotion of mental health and wellbeing. *International Journal of Mental Health Systems*, 2, 13. <https://doi.org/10.1186/1752-4458-2-13>
- Goldmann, E., & Galea, S. (2014). Mental health consequences of disasters. *Annual Review of Public Health*, 35, 169-183. <https://doi.org/10.1146/annurev-publhealth-032013-182435>
- Haverkamp, C. J. (2017). Communication-Focused Therapy (CFT) for anxiety and panic attacks. *J Psychiatry Psychotherapy Communication*, 6(4), 91-95. <https://jonathanhaverkamp.com/communication-focused-therapy-cft-for-anxiety-and-panic-attacks/>
- Hayes, K., Blashki, G., Wiseman, J., Burke, S., & Reifels, L. (2018). Climate change and mental health: Risks, impacts and priority actions. *International Journal of Mental Health Systems*, 12, 28. <https://doi.org/10.1186/s13033-018-0210-6>
- Hickman, C., Marks, E., Pihkala, P., Clayton, S., Lewandowski, R. E., Mayall, E. E., Wray, B., Mellor, C., & van Susteren, L. (2021). Climate anxiety in children and young people and their beliefs about government responses to climate change: A global survey. *The Lancet Planetary Health*, 5(12), e863-e873. [https://doi.org/10.1016/S2542-5196\(21\)00278-3](https://doi.org/10.1016/S2542-5196(21)00278-3)
- Hogg, T. L., Stanley, S. K., O'Brien, L. V., Wilson, M. S., & Watsford, C. R. (2021). The Hogg Eco-Anxiety Scale: Development and validation of a multidimensional scale. *Global Environmental Change*, 71, 102391. <https://doi.org/10.1016/j.gloenvcha.2021.102391>
- Hwong, A. R., Wang, M., Khan, H., Chagwedera, D. N., Grzenda, A., Doty, B., Benton, T., Alpert, J., Clarke, D., & Compton, W. M. (2022). Climate change and mental health research methods, gaps, and priorities: A scoping review. *The Lancet Planetary Health*, 6(3), e281-e291. [https://doi.org/10.1016/S2542-5196\(22\)00012-2](https://doi.org/10.1016/S2542-5196(22)00012-2)
- Intergovernmental Panel on Climate Change. (2022). Climate change 2022: Impacts, adaptation and vulnerability. Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change. <https://www.ipcc.ch/report/ar6/wg2/>
- Ojala, M. (2012). Hope and climate change: The importance of hope for environmental engagement among young people. *Environmental Education Research*, 18(5), 625-642. <https://doi.org/10.1080/13504622.2011.637157>

Haverkamp, C. J. (2022). Climate Anxiety and Ecological Grief: Distress, Impairment, and Care. *J Psychiatry Psychotherapy Communication*, 2022 Sep 30;11(3):81-90

- Ojala, M. (2013). Coping with climate change among adolescents: Implications for subjective well-being and environmental engagement. *Sustainability*, 5(5), 2191-2209. <https://doi.org/10.3390/su5052191>
- Ojala, M., Cunsolo, A., Ogunbode, C. A., & Middleton, J. (2021). Anxiety, worry, and grief in a time of environmental and climate crisis: A narrative review. *Annual Review of Environment and Resources*, 46, 35-58. <https://doi.org/10.1146/annurev-environ-012220-022716>
- Palinkas, L. A., & Wong, M. (2020). Global climate change and mental health. *Current Opinion in Psychology*, 32, 12-16. <https://doi.org/10.1016/j.copsyc.2019.06.023>
- Pihkala, P. (2020). Anxiety and the ecological crisis: An analysis of eco-anxiety and climate anxiety. *Sustainability*, 12(19), 7836. <https://doi.org/10.3390/su12197836>
- Stanley, S. K., Hogg, T. L., Leviston, Z., & Walker, I. (2021). From anger to action: Differential impacts of eco-anxiety, eco-depression, and eco-anger on climate action and wellbeing. *The Journal of Climate Change and Health*, 1, 100003. <https://doi.org/10.1016/j.joclim.2021.100003>
- Verplanken, B., Marks, E., & Dobromir, A. I. (2020). On the nature of eco-anxiety: How constructive or unconstructive is habitual worry about global warming? *Journal of Environmental Psychology*, 72, 101528. <https://doi.org/10.1016/j.jenvp.2020.101528>
- World Health Organization. (2022). Mental health and climate change: Policy brief. <https://www.who.int/publications/i/item/9789240045125>
- Wullenkord, M. C., Tröger, J., Hamann, K. R. S., Loy, L. S., & Reese, G. (2021). Anxiety and climate change: A validation of the Climate Anxiety Scale in a German-speaking quota sample and an investigation of psychological correlates. *Climatic Change*, 168, 20. <https://doi.org/10.1007/s10584-021-03234-6>