Journal of Psychiatry
Psychotherapy & Communication

Haverkampf, C. J. (2023). Prolonged Grief Disorder: Distinguishing Enduring Grief from Depression and Supporting Adaptive Mourning. J Psychiatry Psychotherapy Communication, 2023 Mar 31;12(1):21-30

Prolonged Grief Disorder: Distinguishing Enduring Grief from Depression and Supporting Adaptive Mourning

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Narrative Clinical Review

Abstract—Grief is not an illness simply because it is intense, recurrent, or visible long after a death. Yet a minority of bereaved people experience persistent yearning or preoccupation, marked impairment, and a life that remains organized around the loss. Prolonged grief disorder (PGD) gives clinicians a language for that pattern, but its responsible use requires more than counting symptoms against a calendar. This narrative clinical review considers evidence available through 28 February 2023. It distinguishes PGD from ordinary grief, major depression, post-traumatic stress disorder, adjustment reactions, and the effects of traumatic or socially unrecognized loss. Assessment attends to separation distress, function, risk, culture, continuing bonds, and the meaning of the relationship rather than presuming a universal course. Randomized trials support structured grief-focused psychotherapies that combine an accepting therapeutic relationship with work on painful memories, avoidance, restoration, and future connection. Medication may be appropriate for comorbid disorders; evidence does not support treating grief itself as ordinary depression. The clinical aim is neither detachment from the person who died nor compulsory closure. It is renewed flexibility: the capacity to approach the reality and pain of the death, carry an evolving bond, re-enter valued life, and communicate needs without having grief policed by either silence or a diagnostic timetable.

Index Terms—prolonged grief disorder, bereavement, depression, post-traumatic stress disorder, grief-focused psychotherapy, continuing bonds

I. INTRODUCTION

Grief has no single emotional temperature. It may be anguished, numb, relieved, angry, tender, disorganizing, or intermittently ordinary. Its recurrence months or years after a death does not by itself signal pathology. A familiar song, a legal task, an anniversary, or a new family milestone can restore the loss to the foreground without undoing adaptation. Clinical language is useful only if it protects this breadth while recognizing the smaller group whose grief remains persistently disabling.

Prolonged grief disorder (PGD) was included in ICD-11 and, in 2022, in DSM-5-TR. The classifications differ in timing and some wording, but both locate the core in enduring separation distress accompanied by additional symptoms and impairment beyond cultural expectations (American Psychiatric Association, 2022; World Health Organization, 2022). A diagnosis is therefore not made by sorrow plus elapsed time. It requires a sustained syndrome, consequential dysfunction, and contextual judgment.

That judgment matters because bereavement can also precipitate major depression, post-traumatic stress disorder (PTSD), substance misuse, sleep disturbance, or physical illness. These conditions can coexist with PGD and may need their own treatment. Conversely, diagnosing depression whenever a bereaved person cries, withdraws for a time, or thinks frequently about the deceased can turn a human attachment response into a nonspecific disorder and direct care away from the loss that needs to be spoken about.

This review argues for a twofold discipline: do not medicalize ordinary mourning, and do not abandon a person to severe, enduring impairment in the name of normality. The therapeutic goal is not forgetting, detachment, or an externally imposed endpoint. It is greater freedom to move between grief and life, to hold the relationship in a form that can change, and to take part again in present relationships and responsibilities.

Clinical language can either widen or narrow that freedom. Words such as stuck, unresolved, or failed mourning may communicate concern, but they can also imply that the bereaved person is responsible for an abnormal attachment. More useful language identifies the observed difficulty: the

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person remains unable to enter the home, experiences daily yearning that prevents sleep, or has stopped all valued contact. Specificity permits compassion, disagreement, and a treatment target without declaring the relationship itself excessive.

II. SCOPE AND REVIEW METHOD

This narrative clinical review considered literature publicly available through 28 February 2023, one calendar month before the issue date. Priority was given to official diagnostic sources, systematic reviews and meta-analyses, psychometric and longitudinal studies, and randomized trials of adult grief-focused interventions. Earlier conceptual papers were retained where they shaped current assessment or treatment. Complete online-first articles were eligible when their public date preceded the cutoff.

Search concepts included prolonged or complicated grief, bereavement, depression, PTSD, traumatic loss, culture, continuing bonds, assessment, psychotherapy, cognitive-behavioral treatment, interpersonal psychotherapy, and pharmacotherapy. The terminology changed across the literature. Studies using complicated grief, persistent complex bereavement disorder, or earlier PGD criteria were interpreted according to the construct and measures actually used, not relabeled as if all diagnostic definitions were identical (Shear et al., 2011; Maciejewski et al., 2016).

No new systematic review or meta-analysis was undertaken. The treatment literature comes disproportionately from specialist teams, Western settings, and help-seeking adults; many trials predate DSM-5-TR. Prevalence estimates depend on sampling, type of death, criterion set, and cultural context. Findings are therefore used to inform clinical reasoning rather than to imply a universal natural history or a precise rate for an individual service.

One earlier JPPC article on treatment-resistant PTSD was read in full because it discusses trauma, meaning, interpersonal connection, and communication in psychotherapy (Haverkampf, 2016). Its use here is contextual, not evidentiary, and its archival page discrepancy is disclosed in the accompanying source audit. No other earlier JPPC item was included merely for thematic proximity.

Evidence was weighed by its proximity to each claim. Randomized comparisons and meta-analyses inform treatment efficacy; longitudinal and psychometric studies inform course and classification; conceptual and cultural papers identify questions that trials often omit. None resolves an individual's values or the meaning of a death. The review therefore avoids converting population estimates into predictions and marks clinical practices as interpretive where direct tests are absent.

III. ORDINARY GRIEF IS VARIABLE, NOT DISORDER

Acute grief commonly includes waves of yearning, disbelief, bodily distress, difficulty concentrating, changes in sleep and appetite, and a temporary narrowing of attention toward the person who died. These experiences can be profound without forming a mental disorder. Over time, many people become able to move between attending to the loss and engaging with ordinary life. The pain may remain meaningful, while its dominance and functional cost change (Zisook & Shear, 2009; Shear, 2012).

Adaptation is not linear. A better week does not prove completion, and a worse anniversary does not erase progress. A prospective study that began before spousal loss found several trajectories, including a substantial resilient pattern rather than one required sequence of distress and recovery (Bonanno et al., 2002). Trajectory research describes groups, not destinies. It should widen expectations, not create a new demand that a bereaved person be resilient quickly.

The relationship and circumstances shape the response. The death of a child, partner, sibling, parent, friend, colleague, former partner, or abusive relative may carry different attachment, identity, practical, and social consequences. Relief and grief can coexist, especially after prolonged illness or a harmful relationship. Clinicians should not use warmth toward the deceased as a test of legitimate mourning, nor assume that ambivalence makes the loss easier.

Social recognition also matters. Losses may be minimized when the relationship was private, stigmatized, nonmarital, same-sex, distant, conflicted, or not recognized by an employer or family. Disenfranchisement can deprive the bereaved person of rituals, leave, financial protection, and listeners. What appears to be withdrawal may partly be a response to being repeatedly told that the relationship did not count or that grief should now be finished.

Support for ordinary grief is often practical and relational rather than clinical. Reliable contact, help with administrative demands, permission to remember, sleep and medical care, culturally meaningful ritual, and protection from avoidable pressures may be enough. Routine preventive psychotherapy for every bereaved person has not shown a dependable benefit; meta-analytic work has found stronger effects when intervention is directed toward people with elevated or persistent symptoms (Wittouck et al., 2011; Johannsen et al., 2019).

Digital life complicates ordinary boundaries. Social-media reminders, memorial pages, archived messages, location histories, and automated anniversary prompts can console, intrude, or do both. The clinician asks what happens before and after viewing rather than advising routine deletion or preservation. A chosen digital ritual may support a continuing bond; repeated checking that displaces sleep and present

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relationships may belong in the formulation. The technology changes access to reminders, not the basic need to understand their function.

IV. WHEN GRIEF BECOMES PROLONGED AND IMPAIRING

PGD names a particular organization of suffering. Yearning for or preoccupation with the deceased remains central, additional symptoms persist, and the person experiences clinically significant distress or impairment beyond what their social and cultural context would expect. DSM-5-TR requires the death to have occurred at least twelve months earlier in adults; ICD-11 uses a minimum of six months while emphasizing that a longer period may be needed where mourning commonly continues (American Psychiatric Association, 2022; World Health Organization, 2022).

The interval is a threshold for considering diagnosis, not a forecast and not an appointment to recover. Severe early distress can require active support and risk care without being called PGD. Equally, reaching twelve months does not make continuing yearning pathological. The clinician asks whether the pattern is pervasive and persistent, whether life remains substantially constricted, and whether the intensity and duration exceed relevant norms.

Empirical work supported the construct before its present classifications. Proposed criteria showed psychometric coherence and prospective associations with impairment, and later work supported DSM-5-TR criteria and the PG-13-Revised measure (Prigerson et al., 2009; Prigerson et al., 2021). Analyses comparing proposed syndromes also found considerable overlap between PGD and persistent complex bereavement disorder, while cautioning against assuming that every historical label or scale is interchangeable (Maciejewski et al., 2016).

Population estimates require restraint. A meta-analysis of adult bereavement after natural deaths estimated a pooled prevalence near one in ten, but heterogeneity and study selection limit transportability (Lundorff et al., 2017). A separate synthesis after unnatural deaths found substantially higher and highly variable estimates associated with circumstances and study methods (Djelantik et al., 2020a). Neither figure can determine whether a particular person's response is disordered.

Diagnosis can open access to specific care and communicate that persistent grief is treatable. It can also be misused as a timetable, especially where service rules reward a code more than a formulation. The best safeguard is to show the reasoning: what core symptoms persist, how they interfere, what cultural consultation was obtained, what alternatives were considered, and what the person wants help to change.

Functional impairment must also be interpreted against opportunity. A retired person, full-time caregiver, or someone excluded from work may not display the occupational marker that a checklist anticipates. Another person may keep working while abandoning health care, friendships, meals, or rest. Assessment should sample several domains and ask about effort and sustainability. Visible productivity can conceal a life narrowed around grief just as temporary work absence can reflect humane leave rather than disorder.

Table 1. Diagnostic frameworks and the questions they leave to clinical judgment

Framework	Core emphasis	Time requirement in adults	Clinical caution
Ordinary bereavement	Variable attachment response that usually becomes more integrated	No diagnostic clock	Intensity, recurrence, or an anniversary wave alone is not disorder
DSM-5-TR PGD	Yearning or preoccupation plus associated symptoms, impairment, and contextual excess	At least 12 months after death	A threshold permits assessment; it does not prove pathology
ICD-11 PGD	Persistent, pervasive longing or preoccupation with emotional pain and impairment	At least 6 months, longer where culture requires	Cultural and religious context is part of the definition, not an afterthought
Earlier research constructs	Complicated grief, PGD, or persistent complex bereavement criteria and scales	Varied across studies	Do not translate trial eligibility mechanically into a current diagnosis

V. DIFFERENTIAL: GRIEF, DEPRESSION, PTSD, AND OTHER BURDEN

PGD and major depression can share sadness, sleep disturbance, guilt, social withdrawal, and diminished interest. Their centers of gravity differ. In PGD, distress is usually organized around separation, yearning, and difficulty integrating the death. In depression, low mood and loss of pleasure are more generalized, self-evaluation may become globally negative, and hopelessness extends beyond the lost relationship. A bereaved person can meet criteria for both; one diagnosis should not erase the other (Zisook & Shear, 2009; Szuhany et al., 2021).

PTSD is organized principally around threat and trauma rather than separation, although a violent or disturbing death can produce both. Intrusions in PTSD tend to re-present the threatening event; grief intrusions may concern the deceased, the finality of separation, or an imagined future that will not occur. Avoidance can look similar while serving different feared outcomes. In a treatment-seeking trauma-exposed sample, latent-class and network analyses supported distinguishable but interconnected PGD, PTSD, and depression symptom patterns (Djelantik et al., 2020b).

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Co-occurrence is easier to see when the clinician follows a single episode from cue to consequence. A photograph may evoke yearning and searching, an image of the death may trigger threat and physiological alarm, and the conclusion that nothing can ever matter may broaden into depressive hopelessness. The same evening can contain all three sequences. Mapping them avoids arguing over one correct label and identifies different treatment targets: separation distress, trauma memory, generalized depressive withdrawal, or a combination. Network findings support overlap without collapsing the syndromes, but they do not determine priority for an individual (Djelantik et al., 2020b). Priority is set collaboratively by risk, impairment, the patient's aims, and which process prevents engagement with the others.

The distinction changes the conversation. Asking only about what happened at the death may miss longing, identity disruption, and difficulty reconnecting. Asking only about missing the person may miss terror, nightmares, physiological reactivity, or moral injury related to the manner of death. Prior JPPC discussion of treatment-resistant PTSD emphasizes meaning, safety, and interpersonal communication, which can enrich formulation, but trauma treatment evidence must still come from the relevant external literature (Haverkampf, 2016).

Adjustment disorder, anxiety disorders, substance problems, insomnia, and somatic illness also enter the differential. Cognitive impairment, medication effects, pain, endocrine illness, and the practical exhaustion of caregiving or estate administration can intensify concentration and sleep complaints. Psychotic experiences, mania, severe self-neglect, and delirium require their own assessment rather than being normalized as grief.

Brief sensory experiences of the deceased can occur in bereavement without implying psychosis, particularly when insight and function remain intact. The clinician asks about form, frequency, meaning, distress, conviction, and consequences. Similarly, guilt may reflect a realistic omission, a trauma-related distortion, survivor guilt, or a general depressive indictment of the self. Naming all guilt irrational would be as careless as accepting every accusation the mind produces.

Temporal pattern offers another clue but not a diagnostic shortcut. Grief often surges around reminders and can coexist with moments of interest or warmth; depression may feel more pervasive across topics and settings. PTSD symptoms may intensify in cues linked to threat rather than attachment. These distinctions blur in real life and depend on careful examples. The clinician should ask what occupies the mind during withdrawal and what the person believes would happen if they approached the avoided situation.

VI. CULTURE, SPIRITUALITY, AND THE DANGER OF A UNIVERSAL CLOCK

Culture shapes who is mourned publicly, how emotion is expressed, what obligations continue, how the dead are understood, and when renewed participation is expected. Diagnostic systems acknowledge this, yet a criterion such as being beyond social or cultural norms cannot be applied from a clinician's intuition alone. International discussion of ICD-11 emphasized clinical utility and global applicability, while also recognizing the difficulty of defining a disorder across diverse mourning practices (Killikelly & Maercker, 2018).

A cultural formulation asks about the person's family, community, faith, migration history, rituals, language, and position within those worlds. It also asks whether a stated norm is supportive or coercive. Communities are not uniform; gender, generation, class, sexuality, disability, and personal belief can change what is permitted. Consultation can help, but the patient should not be reduced to a presumed group custom.

Global crises make the question sharper. Large-scale death, disrupted funerals, forced migration, conflict, and unequal access to care can interrupt ordinary mourning and expose the bereaved person to repeated threat. A critical cultural account warns that exporting one grief template can obscure social conditions and indigenous or local meanings (Stelzer et al., 2020). Treatment should not describe deprivation of ritual or justice as a private failure to adapt.

Spiritual and existential concerns may be central, peripheral, consoling, conflicted, or absent. Clinicians can ask what the person believes happened to the deceased, whether those beliefs have changed, and whether spiritual communities are a resource or a source of judgment. The task is not to settle metaphysical questions. It is to make room for their psychological and relational significance without imposing reassurance.

Language access is part of cultural safety. A translated symptom word may not carry the same boundaries as yearning, preoccupation, numbness, or identity disruption. Professional interpreters need a brief about the clinical purpose and space to note where no direct equivalent exists. Family members should not be recruited automatically to translate intimate grief or risk. The clinician can ask the person which language best holds the relationship and allow important terms to remain in that language while meaning is explored.

VII. ATTACHMENT, MEANING, AND CONTINUING BONDS

Mourning does not require erasing a relationship. A continuing bond may be expressed through memory, values, ritual, conversation, objects, creative work, or an internal sense of guidance. Such bonds can coexist with adaptation;

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their usefulness depends on form and function rather than simple presence (Field, 2006). The question is whether the bond can evolve while the person also inhabits a present life.

Difficulties can arise when the mind cannot integrate the factual and emotional reality of the death. The person may know that the death occurred yet repeatedly behave as if reunion remains immediately possible, avoid every reminder, or preserve the environment so rigidly that time cannot enter it. At another extreme, compulsory removal of possessions or demands to stop speaking of the deceased can make treatment another enactment of social silencing.

Meaning-making is not the demand to find a positive reason for a death. Some deaths remain senseless, unjust, or preventable. Therapy may instead help the person articulate what was lost, what the relationship made possible, what responsibilities genuinely remain, and what values can still be enacted. This work can include anger at institutions or relatives; reconciliation with events is not the same as approving them.

Identity often changes with the relationship. A person is no longer an everyday spouse, caregiver, sibling, or child in the same way, while the relational history remains part of who they are. Restoration involves practical roles and new relationships as well as cognition. It should not be presented as replacement. A new attachment neither betrays the deceased nor cancels the singularity of the earlier bond.

VIII. ASSESSMENT AS A CAREFUL CONVERSATION

Assessment begins with the person's own account of the death and current difficulty. A clinician can ask what has changed, what remains most painful, what situations are avoided, how days are organized, and what the person fears would happen if life expanded. This approach identifies the syndrome without making the interview a test of whether grief looks sufficiently normal.

Time and function need specificity. The date of death is documented, but so are the pattern and reach of symptoms: work, caregiving, sleep, nutrition, finances, health care, relationships, pleasure, and the capacity to plan. A person may function publicly at great cost and collapse in private. Another may be unable to work because of economic or physical circumstances rather than PGD. Impairment must be connected to mechanism.

Validated measures can structure inquiry and monitor change. The PG-13-Revised reflects DSM-5-TR criteria, while the Traumatic Grief Inventory-Self Report Plus can assess several contemporary criterion sets (Prigerson et al., 2021; Lenferink et al., 2022). A score is not a diagnosis. Self-report is shaped by interpretation, literacy, language, culture, and the moment in which it is completed.

The conversation includes the relationship before the death, caregiving and conflict, circumstances of the death, opportunity to say goodbye, ritual, support, stigma, and secondary losses. Idealization is not corrected by forcing negative memories, and ambivalence is not treated as resistance. Both can be approached when the person has enough safety to hold a fuller relationship story.

Finally, assessment asks what help would matter. Some people want relief from intrusive images; others want to enter a room left unchanged, speak to children about the death, return to work, sleep, or experience pleasure without guilt. A treatment target expressed in lived terms provides a better guide than the abstract instruction to move on.

Assessment is not completed in one interview when trust, exhaustion, or cultural difference limits disclosure. Repeated review can distinguish a stable pattern from an anniversary wave and reveal risks initially hidden by shame. It also protects against diagnostic momentum: if sleep improves and generalized hopelessness lifts while separation distress remains, the formulation can change. The person should hear that revision is evidence of careful care, not proof that their earlier account was unreliable.

A compact PGD assessment conversation

- Anchor: clarify the death, relationship, time course, and the person's words for what persists.
- Core pattern: ask about yearning, preoccupation, identity, disbelief, emotional pain, avoidance, numbness, meaning, loneliness, and impairment.
- Differentiate: map separation distress, generalized depression, threat-based PTSD, substance use, sleep, medical burden, and cognition separately.
- Context: ask about culture, faith, ritual, recognition of the relationship, practical losses, discrimination, and available support.
- Safety: ask directly about self-harm, suicide, self-neglect, violence, substances, and the ability to use support.
- Goal: identify one change the person wants without requiring detachment, forgiveness, or reconciliation.

IX. RISK, TRAUMATIC DEATH, AND COMORBIDITY

Bereavement can heighten suicide risk, and severe persistent grief deserves direct inquiry about wishing to die, plans, access to means, reasons for living, substance use, and previous behavior. A wish to be reunited with the deceased may range from metaphorical longing to imminent intent. The clinician should not assume its meaning, nor avoid the question for fear of disrupting rapport (Shear et al., 2011).

Risk is not static across the diagnostic interval. Birthdays, anniversaries, inquests, criminal proceedings, estate decisions, media coverage, a child's milestone, or the end of practical support may change it abruptly. Review should therefore be timed to foreseeable transitions and repeated after new losses or treatment changes. The clinician distinguishes passive thoughts that life is not worth continuing, a desire to join the

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deceased, rehearsed scenarios, intent, preparation, and access to means; none can be inferred from a grief score. Protective factors are also made concrete—who can be contacted, which responsibility or relationship still anchors the person, and what has interrupted action before. A collaborative plan should be usable when concentration is poor, not dependent on recalling a complex discussion (Shear et al., 2011; Szuhany et al., 2021).

Traumatic and unnatural deaths can add exposure to violence, uncertainty, legal proceedings, public attention, blame, or disturbing images. Meta-regression suggests a high and heterogeneous burden of PGD after unnatural loss, but individual outcomes still vary (Djelantik et al., 2020a). Suicide, homicide, disaster, and preventable medical deaths can also bring stigma, moral questions, and fractured family narratives that require more than symptom management.

Comorbidity is common enough to assess deliberately but not to presume. Major depression may require antidepressant or depression-focused psychotherapy; PTSD may require trauma-focused treatment; substance dependence may need coordinated care. Sequencing is guided by acute risk, capacity to engage, and which process currently blocks the other. Stabilization should be proportionate and should not become indefinite postponement of grief-focused work.

Risk management remains relational and practical. A plan names warning signs, means-restriction steps, people and services to contact, and barriers likely to arise when concentration and hope are low. Clinicians also attend to nutrition, medication, medical appointments, housing, caregiving, and occupational consequences. These are not peripheral to psychotherapy; they determine whether the person has enough footing to use it.

X. WHAT GRIEF-FOCUSED PSYCHOTHERAPY DOES

Structured grief-focused psychotherapy has the clearest direct treatment evidence. In an early randomized trial, complicated grief treatment outperformed interpersonal psychotherapy, establishing that a loss-focused approach could add benefit beyond a credible therapy (Shear et al., 2005). Trials in older adults and later multicenter work replicated the advantage of grief-focused treatment over interpersonal management for the grief syndrome (Shear et al., 2014; Shear et al., 2016).

The treatment is not one technique. It builds a collaborative understanding of grief, restores routines and connection, approaches avoided reminders, revisits the story of the death, addresses painful appraisals, and supports goals that have become difficult to imagine. A review of the treatment model describes attention to both loss and restoration rather than an instruction to relinquish the bond (Wetherell, 2012).

Cognitive-behavioral trials provide convergent evidence. Exposure combined with cognitive restructuring produced greater improvement than supportive counseling in one study, and a later randomized trial supported a CBT program for PGD (Boelen et al., 2007; Bryant et al., 2014). Across randomized trials, meta-analysis finds an overall benefit of psychological interventions, while study quality, populations, timing, and intervention components remain heterogeneous (Johannsen et al., 2019).

The therapeutic relationship carries special weight because shame, fear of judgment, and social pressure often surround persistent grief. Validation is not passive agreement that life cannot change. It communicates that the bond and pain make sense while inviting the person to examine how avoidance, guilt, or a frozen future now operates. Change becomes something done with the grief rather than against the deceased.

Treatment choice should reflect preference, access, culture, comorbidity, cognitive capacity, and previous care. A protocol can be adapted without deleting its active grief focus. Conversely, offering generic supportive listening indefinitely while avoiding memories, behavior, and restoration may feel kind yet leave the maintaining processes untouched. The patient should know what the proposed treatment will ask of them and what evidence directly supports it.

Monitoring should test the formulation rather than merely document symptom decline. If the person attends faithfully but remains unable to approach reminders, the obstacle may be fear, dissociation, an unclear rationale, or a practical barrier rather than unwillingness. If memories become less distressing while life remains empty, restoration and social reconnection may need more attention. If generalized depression, intoxication, cognitive change, or continuing danger dominates, the plan may need coordination or a different sequence. Meta-analytic benefit across grief interventions does not identify one necessary component for every patient, and heterogeneity cautions against treating a protocol name as a guarantee (Johannsen et al., 2019). Reviewing gains, burdens, alliance, and adverse effects allows adaptation without quietly turning nonresponse into a character judgment.

Pacing is a shared clinical decision rather than a test of courage. A person who becomes flooded, dissociative, medically unwell, or unable to function after memory work may need a smaller dose, stronger grounding, a different sequence, or reassessment of the formulation. Temporary distress during meaningful work is not automatically harm, but neither should deterioration be romanticized. Monitoring includes symptoms, sleep, safety, function, alliance, and whether the person continues to understand and endorse the rationale.

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Table 2. Components of grief-focused treatment and their clinical purpose

Component	Clinical purpose	Common failure mode	Protective practice
Shared grief formulation	Connect attachment, triggers, avoidance, appraisals, and impairment	Turning a diagnosis into a timetable	Use the person's goals and cultural context
Approaching the death story	Integrate painful memory and reduce rigid avoidance	Flooding, coercion, or fixation on detail	Obtain consent, pace work, and review what is learned
Situational re-engagement	Recover places, activities, roles, and relationships	Treating busyness as recovery	Link each step to meaning and function
Cognitive and meaning work	Examine guilt, blame, identity, finality, and future	Demanding a positive lesson or premature forgiveness	Distinguish facts, responsibility, uncertainty, and values
Continuing bond	Develop a flexible, chosen relationship to memory	Prescribing detachment or one ritual	Ask what form of connection supports present life

XI. EXPOSURE, MEMORY, AND RESTORATION WITHOUT COERCION

Exposure in grief treatment is easily misunderstood. Its purpose is not to make the death emotionally neutral or to prove that sorrow is irrational. Repeated, planned contact with the story or reminders can help the mind integrate finality, distinguish memory from present danger, and discover that emotion can be experienced without endless avoidance. The patient needs a clear rationale, meaningful choice, and a shared method for adjusting pace.

Avoidance is assessed by function rather than appearance. Keeping photographs may support connection or prevent any contact with the finality of the death; removing every object may support a needed transition or suppress memory. Visiting a grave may be meaningful, culturally required, feared, or irrelevant. Therapy tests what a behavior does in this person's life instead of assigning a fixed meaning to the behavior itself.

Restoration work runs alongside loss work. It can include sleep, household tasks, finances, parenting, friendship, sexuality, creativity, spiritual practice, or a return to work. Small steps are not distractions when they rebuild an environment in which grief can be carried. They become problematic only when activity is used rigidly to prevent any contact with the loss.

Treatment reviews prediction and outcome. A person may expect that laughing will betray the deceased, entering a room will cause permanent collapse, or telling the full story will make the image uncontrollable. The experiment records what occurred, what was tolerable, and what remains difficult. Success is not the absence of tears; it is increased choice, accuracy, and capacity to remain connected to both memory and present life.

XII. MEDICATION, SUPPORT, AND STEPPED CARE

Medication evidence should be described narrowly. In a large randomized trial, adding citalopram did not enhance the grief response to complicated grief treatment, although it improved co-occurring depressive symptoms; grief-focused psychotherapy was the decisive element for the grief outcome (Shear et al., 2016). This finding does not show that antidepressants never help bereaved patients. It shows why PGD should not be treated as depression by default.

Medication may be indicated for a comorbid major depressive episode, anxiety disorder, severe insomnia within a broader plan, or another condition after ordinary assessment of benefit, adverse effects, interactions, and preference. The prescriber explains which target is being treated and monitors it separately. Sedation that numbs distress while worsening function should not be mistaken for grief recovery.

Stepped care begins with accurate recognition. Many bereaved people need social and practical support; some benefit from facilitated groups or brief counseling; those with persistent disabling symptoms may need a structured grief-focused therapy. Severity alone does not determine format. Geography, finances, language, disability, safety, and the availability of trained clinicians shape what can actually be offered (Shear, 2015; Szuhany et al., 2021).

Peer, family, community, faith, hospice, and primary-care supports can complement psychotherapy when the person wants them. Groups may reduce isolation, but a poor fit can increase it; stories of traumatic death can also be activating. Clinicians should discuss confidentiality, purpose, facilitation, and whether the group welcomes the person's relationship, culture, and way of mourning.

XIII. COMMUNICATION WITH FAMILIES, WORKPLACES, AND SERVICES

Bereaved people often face two incompatible messages: speak so others can help, and stop speaking because others are uncomfortable. Therapy can prepare concise, specific requests without implying that the bereaved person must educate everyone. A request such as needing advance notice of a memorial discussion, one practical task, or a quiet room at an anniversary gives another person something possible to answer.

Families can hold different grief rhythms and meanings. One person wants photographs visible; another cannot tolerate them. One wants details of the death; another needs limits. Difference is not evidence that one cared more. A useful conversation names the shared loss, the distinct need, and a time-limited arrangement that can be revisited. Where there was abuse or coercion, joint grieving should never be required.

Workplaces and services can reduce preventable harm through flexible leave, staged return, predictable contact, and

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avoidance of euphemistic pressure to be back to normal. The clinician's letter should disclose only what is necessary and, with consent, describe functional needs rather than intimate details. Formal diagnosis may support access, but accommodations should not depend on proving grief in a culturally favored style.

Clinical communication should preserve uncertainty. Rather than declaring that someone is stuck, the clinician can say that yearning and avoidance remain severe, work has not resumed, and the pattern may meet PGD criteria after cultural review. This language makes observations and interpretation visible. It also leaves room for the person to disagree, add context, and decide whether the offered treatment fits.

Transitions between services deserve the same precision. A handover can state which diagnostic criteria were considered, how cultural expectations were explored, what risks and comorbidities remain active, what the patient calls the problem, and which interventions helped or worsened it. Merely writing bereavement can minimize a disabling syndrome; merely writing PGD can erase the relationship, circumstances, and uncertainty. The receiving clinician should know whether a measure tracked change and which version it reflected, because contemporary instruments do not map identically onto every historical construct (Lenferink et al., 2022). With consent, a concise formulation prevents the person from having to prove the death and retell its most painful details at every doorway. Continuity is not administrative courtesy; it protects meaning, safety, and treatment choice.

Table 3. Communication tasks around prolonged grief

Setting	Unhelpful shortcut	More precise communication	Boundary
Clinical assessment	You should be over this	Your grief remains intense and is severely limiting life; may we examine why?	Diagnosis requires symptoms, impairment, time, and context
Family	We all need to grieve together	We may need different rituals, information, and amounts of contact	Do not use mourning to override safety or consent
Work	Return when you are normal	Specify temporary functional needs and a review point	Share the minimum health information necessary
Anniversary	Do not dwell on it	Plan how the person wants the date recognized and supported	Permission includes choosing privacy
Treatment planning	Medication or time will fix grief	Name the target, evidence, burden, and alternatives	Grief-focused care is not compulsory detachment

XIV. LIMITATIONS

The modern evidence base is clinically useful but uneven. Diagnostic studies have used changing criteria and measures, and much treatment research concerns the earlier construct of complicated grief. DSM-5-TR PGD is closely related, not retroactively identical to every enrolled sample. Prevalence syntheses combine studies that differ in loss type, recruitment, culture, timing, and threshold (Lundorff et al., 2017; Rosner et al., 2021).

Randomized trials support grief-focused psychotherapy, yet specialist delivery, researcher allegiance, selective eligibility, attrition, and limited cultural diversity constrain generalization. Meta-analyses cannot make heterogeneous interventions or populations interchangeable (Wittouck et al., 2011; Johannsen et al., 2019). Evidence is thinner for people with cognitive impairment, unstable housing, active addiction, severe physical illness, or ongoing exposure to conflict and repeated loss.

Cultural clauses in diagnostic definitions do not by themselves ensure culturally safe practice. Research instruments are often translated more readily than the underlying assumptions are examined. The literature still needs locally grounded validation, attention to collective and historical loss, and outcomes that include social participation, meaning, and care access rather than symptoms alone.

This is a narrative review, not a guideline or quantitative synthesis. Its practice recommendations integrate direct trial evidence with broader bereavement research and professional interpretation. Where evidence is indirect, the clinician should say so, seek consultation, monitor the chosen target, and change course when the person is not benefiting or feels that treatment is policing the bond.

Access is a further limitation of efficacy claims. Trials can show that a trained specialist treatment helps selected participants without showing that services can deliver it in the person's language, location, timeframe, or financial circumstances. Waiting lists may leave risk and impairment untreated, while a diagnostic label without a pathway can deepen hopelessness. Implementation research should examine training, fidelity, adaptation, stepped formats, digital delivery, and harms without assuming that shorter or remote care is equivalent.

XV. CONCLUSION

Prolonged grief disorder identifies enduring separation distress and impairment, not grief that has merely survived a date. Responsible diagnosis places the person's symptoms, function, relationship, culture, circumstances of death, and other disorders in the same formulation. Ordinary grief remains broad; depression and PTSD remain distinct even when they coexist.

Structured grief-focused psychotherapies have meaningful evidence. Their work is active but need not be coercive: approaching painful memory, testing avoidance, examining

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guilt and meaning, rebuilding roles and connection, and finding a flexible continuing bond. Medication treats defined comorbidity more convincingly than the grief syndrome itself.

The humane clinical position resists both haste and neglect. It does not demand closure, prescribe forgetting, or promise that loss will become good. It offers careful company and evidence-based help so that grief can remain part of a life without remaining the condition under which all life must occur.

XVI. 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.

Funding—No specific funding was reported for this article.

Author contributions—Christian Jonathan Haverkampf is the sole named author and is responsible for the conception, literature review, manuscript preparation, and approval of the final draft.

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

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