Prolonged grief disorder

Clare Killikelly, Kirsten V Smith, Ningning Zhou, Holly G Prigerson, Mary-Frances O'Connor, Cyrille Kossigan Kokou-Kpolou, Paul A Boelen, Andreas Maercker

Prolonged grief disorder is a mental health disorder recently included in diagnostic manuals worldwide. This Review presents published research evidence in strong support for the current conceptualisation of prolonged grief disorder: a diagnosable mental health condition with core symptoms of yearning, preoccupation, or both, which is associated with symptoms of emotional pain, identity disturbances, loss of meaning and purpose, and functional impairment. The public and academic discourse surrounding prolonged grief disorder has catalysed researchers to produce methodologically rigorous research evidence in support of this much-needed diagnosis. A coherent syndrome of prolonged grief disorder has a typical onset of 6 to 12 months after the death of a close person. Prolonged grief disorder is associated with various poor outcomes, including negative health outcomes (eg, high blood pressure), increased rates of suicidality, low life satisfaction, and increased service use. Psychotherapy is the main treatment for prolonged grief disorder. Theoretical models of the cause and maintenance of prolonged grief disorder are presently being refined through the rapidly increasing empirical literature. Awareness of prolonged grief disorder by general health practitioners, as well as mental health specialists, is key to appropriate early intervention.

Lancet 2025; 405: 1621–32

Published Online
April 17, 2025
https://doi.org/10.1016/S0140-6736(25)00354-X

Division of Clinical Intervention and Global Mental Health (C Killikelly DClinPsy PhD) **and Psychopathology and Clinical Intervention, Department of Psychology** (Prof A Maercker PhD); **University of Zurich, Zürich, Switzerland; The Oxford Centre for Anxiety Disorders and Trauma, Department of Experimental Psychology, University of Oxford, Oxford, UK** (K V Smith DClinPsy DPhil); **Shanghai Key Laboratory of Mental Health and Psychological Crisis Intervention, Affiliated Mental Health Center, School of Psychology and Cognitive Science, East China Normal University, Shanghai, China** (N Zhou PhD); **Department of Radiology, Department of Medicine, Weill Cornell Medicine, New York City, NY, USA** (Prof H G Prigerson PhD); **Cornell Center for Research on End-of-Life Care, New York City, NY, USA** (Prof H G Prigerson); **Department of Psychology, University of Arizona, Tucson, AZ, USA** (Prof M-F O'Connor PhD); **School of Psychology, Laval University, Québec, QC, Canada** (C K Kokou-Kpolou PhD); **ARQ Centrum'45, Diemen, Netherlands** (Prof P A Boelen PhD); **Department of Clinical Psychology, Faculty of Social and Behavioural Sciences, Utrecht University, Utrecht, Netherlands** (Prof P A Boelen)

Correspondence to:
Dr Clare Killikelly, Division of Clinical Intervention and Global Mental Health, University of Zurich, Zürich CH-8050, Switzerland
c.killikelly@psychologie.uzh.ch

Introduction

Prolonged grief disorder is a mental health disorder included in diagnostic guidelines worldwide, including the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), published in 2022, and the International Classification of Diseases, 11th Edition (ICD-11), published in 2018.[1,2] This inclusion marks an important step in recognising atypical grief as distinct from normative grief processes. Historically, atypical grief was not formally recognised in earlier versions of the ICD; it was classified under adjustment disorders or misclassified as depressive episodes when bereavement-related symptoms of depression were severe or prolonged. The DSM-3 introduced the bereavement exclusion for major depressive disorder in 1980[3]—ie, major depressive disorder should not be diagnosed in the case of recent bereavement (ie, within 2 months after loss)—but it did not have a distinct category for atypical grief. Persistent complex bereavement disorder was introduced in the DSM-5 in 2013[4] as a condition for further study, describing severe, enduring grief, but not formalised as a diagnosis. These early frameworks laid the foundation for the distinct diagnostic criteria of prolonged grief disorder now included in ICD-11 and DSM-5-TR, which reflect decades of empirical research and clinical insights.[1,2]

Discussions about the pathologisation of grief, stigmatisation, and potential for misdiagnosis have reignited academic and public dialogue challenging the taxonomy of mental disorders and the medical classification of human suffering. Nevertheless, the prolonged grief disorder diagnosis signifies recognition that the typical trajectory of adaptation after bereavement can stall and thus become maladaptive in some cases. A valid and reliable diagnosis of prolonged grief disorder is a step towards improved assessment and treatment for those who need it. This Review presents the robust and rigorously established evidence base for prolonged grief disorder and serves as a resource for clinicians and researchers seeking key research and references on this new mental health disorder. The panel presents definitions of the terms used in this Review.

Experts in grief and bereavement largely agree that a minority of bereaved individuals experience severe, debilitating grief that requires intervention.[5,6] However, the inclusion of prolonged grief disorder as a mental disorder initiated critical debate.[7,8] The different views about the prolonged grief disorder diagnosis can be grouped into two themes: the existential or philosophical theme and the critique of diagnostic culture.[9,10] Existential arguments discuss the decentralised role of death in society,[11] grief as an existential experience leading to other mental health conditions,[12] and grief as a foundational emotion connecting humans to love and death.[13] Critiques of diagnostic culture argue that universal human

Panel: Definitions of terms

Bereavement
The objective situation of having lost a close other through death (eg, losing a spouse).

Mourning
The cultural, social, and religious practices associated with expressing and coping with grief.

Grief
The emotional response to loss, encompassing yearning, identity disturbance, loss of meaning and purpose, and other cognitive, physical, and behavioural reactions.

Prolonged grief disorder
An atypical grief response characterised by severe and persistent yearning or preoccupation, emotional pain, identity disturbance, loss of meaning and purpose, and other cognitive, physical, or behavioural disruptions, and functional impairment beyond social, cultural, and religious norms.

ICD-11 prolonged grief disorder items		DSM-5-TR prolonged grief disorder items	
(A) Event	History of bereavement following the death of a partner, parent, child, or other person close to the bereaved	(A) Event and time	Death of a person at least 12 months ago (for children and adolescents at least 6 months ago)
(B) Separation distress	Persistent and pervasive grief characterised by one or both ofcthe following symptoms: longing for the deceased; or preoccupation with the deceased	(B) Separation distress	Prolonged grief response characterised by one or both of the following symptoms, which have been present most days to a clinically significant degree and have occurred nearly every day for at least the last month before diagnosis: intense yearning or longing for the deceased person; or preoccupation with thoughts or memories of the deceased person (in children and adolescents focus might be on the circumstances of the death)
(C) Emotional pain	Intense emotional pain, for example, might be manifested as sadness, guilt, anger, denial, and blame; difficulty accepting the death; feeling that one has lost a part of oneself; an inability to experience positive mood; emotional numbness; difficulty engaging with social or other activities	(C) Cognitive, emotional, behavioural symptoms	At least three of the following symptoms present nearly every day to a clinically significant degree for at least the last month before diagnosis: identity disruption (eg, feeling that a part of oneself has died); marked sense of disbelief about the death; avoidance of reminders that the person is dead (in children and adolescents, might be characterised by efforts to avoid reminders); intense emotional pain (eg, anger, bitterness, and sorrow) related to the death; difficulty with reintegration (eg, problems engaging with friends, pursuing interests, and planning for the future); emotional numbness (absence or marked reduction of emotional experience); feeling that life is meaningless; intense loneliness
(D) Functional impairment	Grief results in substantial impairment in personal, family, social, educational, occupational, or other important areas of functioning; if functioning is maintained, it is only through substantial additional effort	(D) Functional impairment	The symptoms outlined in (C) cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
(E) Cultural and time criteria	The pervasive grief response has persisted for an atypically long period of time following the loss, markedly exceeding expected social, cultural, or religious norms for the individual's culture and context; grief responses lasting for less than 6 months, and for longer periods in some cultural contexts, do not meet these criteria	(E) Cultural criteria	The duration and severity of the bereavement reaction clearly exceeds expected social, cultural, or religious norms for the individual's culture and context
		(F) Other mental disorders	The symptoms are not better explained by major depressive disorder, post-traumatic stress disorder, or another mental disorder, or attributable to the physiological effects of a substance (eg, medication or alcohol) or to another medical condition

Figure: **Diagnostic criteria for prolonged grief disorder**
DSM-5-TR=Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision. ICD-11=International Classification of Diseases, 11th edition.[1,2]

experiences are being reduced to medical categories. The proliferation of diagnoses risks pathologising the human experience, leading to misdiagnosis, increased medical treatment, and disregard for traditional support systems.[14] Additionally, applying diagnostic labels to individuals might overlook structural, political, and social factors amplifying bereavement-related distress, for example in the case of bereaved humanitarian migrants. Increased rates of prolonged grief disorder by relationship to the deceased (eg, losing a child) or loss characteristics (eg, homicide and drug overdose deaths) are often cited as evidence of over-pathologising normative reactions.[15] These critiques, although reasonable, should be levied at all mental health disorders, not exclusively prolonged grief disorder.[9] For example, interpersonal violence results in the highest rates of conditions such as post-traumatic stress disorder (PTSD),[16] but it would be unlikely that the presence of, or treatment for, PTSD would be denied in the small proportion of the population who develop this disorder.

A call for conceptual competence based in the philosophy of psychiatry and psychology might provide a framework to unite opposing views. For example, in psychiatric and psychological training programmes there should be increased recognition that different philosophical schools view the cause and maintenance of symptoms distinctly and such varying views might prove useful in different contexts.[17] On one end of the philosophical spectrum, symptoms of grief could be understood and studied at the neurobiological level (ie, a reductionist or realist view); at the other end, as the result of social processes and cultural influences (ie, a constructivist view). A pragmatic approach would offer a middle ground, that is, diagnostic criteria catalogue a

disorder, yet do not comprise a disorder.[18] A clearer understanding of the philosophical conceptualisation of mental disorders (ie, a Western-cultural bias and the dominance of neurobiological explanations), could be particularly useful when considering the effect of culture on the expression, experience, and understanding of prolonged grief disorder in a global context. As a practical example, the time criteria for a diagnosis differs between the DSM-5-TR (12 months after the loss) and the ICD-11 (6 months after the loss). A pragmatic approach would consider the individual's symptom severity, culture, context, access to care, systems of support, and personal desires in the diagnostic decision-making process. To understand the small proportion of individuals who continue to experience disabling distress and physiological dysregulation following the death of a close other, the diagnostic criteria provide a starting point towards improved assessment and treatment.

Diagnostic consensus

The journey to establishing diagnostic consensus for a grief-related mental disorder has spanned decades.[19,20] The most recent diagnostic sets, DSM-5-TR[1] and ICD 11,[2] similarly define prolonged grief disorder in terms of core symptoms of separation distress (eg, yearning, preoccupation with the loss), emotional pain, identity disturbance, loss of meaning, and functional impairment, which exceed sociocultural norms and a time criterion (figure).[21]

Differences between these diagnostic sets include the number of symptom items, how precisely symptoms are described, the criteria for time since bereavement, and the specific diagnostic algorithm. Although there are more similarities than differences between current and precursor diagnostic sets—eg, the prolonged grief disorder consensus criteria from Prigerson and colleagues,[22] the criteria for complicated grief from Shear and colleagues,[23] or the beta draft of the ICD-11 prolonged grief disorder critieria from Maercker and colleagues[24]—aligning the diagnostic algorithm and the time criteria could improve diagnostic agreement between the current sets.[21,25] Additionally, whether yearning and preoccupation are pan-cultural core symptoms, and thus have high diagnostic specificity and sensitivity, is still under investigation. Recent evidence suggests that these symptoms are more prevalent in parts of the Global North (ie, high-income countries predominantly, but not exclusively, in the north hemisphere of the Earth), and that other symptoms, such as somatic bodily reactions, are empirically more likely to be core symptoms in other regions of the world.[26]

Differentiation from typical grief

Researchers and clinicians have welcomed global recognition that there exist severe forms of grief that would likely benefit from professional help. Individuals who have prolonged grief disorder have prolonged, intense bereavement-related distress and dysfunction, setting them apart from most bereaved individuals who either maintain stable, healthy functioning after a loss or recover following a brief period of disruption.[27,28] Research using Prigerson and colleagues' version of the prolonged grief disorder criteria[22] found a low rate for false positive diagnosis at 1·4%.[29] Nevertheless, clarifying the conceptual framework for prolonged grief disorder assessment is essential. First, a dimensional understanding of mental health and mental health disorders must be applied (ie, severity of symptoms is continuous). Previous research confirms that prolonged grief disorder and typical grief reactions differ in severity and chronicity, not qualitatively.[30] At the mild end of the spectrum, grief might cause moderate disruption in an acute phase, with grief transforming with time to common human emotion which varies in nature and intensity, whereas at the other end of the spectrum, severe, enduring disruption persists and might only benefit from treatment.[5,9] As symptoms of typical grief and prolonged grief disorder do not qualitatively differ, it is important to consider a stepped model of support where subclinical presentations can be monitored and offered early support when needed.[31,32]

Second, clinical utility and global applicability have been foundational for defining disorders in the ICD-11 revision.[20] Clinical utility is defined as enhanced communication, ease of use, and improved treatment planning.[33] Testing of beta ICD-11 and DSM-5-TR prolonged grief disorder criteria confirmed their clinical utility for case identification and treatment planning.[34] Follow-up studies confirmed the predictive validity of the current and previous iterations of DSM-5-TR and ICD-11 criteria,[22] reliability across community samples[35] and large international samples,[36] and the long-term stability of the prolonged grief disorder diagnosis; the criteria reliability (r=0·86) was higher than any other disorder assessed (ie, PTSD and major depressive disorder).[22] In addition to neurobiological differences discussed later in this Review, ongoing physiological dysregulation is also more common in prolonged grief disorder than in typical grief. In response to a period of intense grief, individuals with higher prolonged grief disorder symptom severity (measured by sum scores from 11 Likert responses of the prolonged grief-13 revised [PG-13-R] scale ranging from 1 [not at all] to 5 [overwhelming], with higher scores indicating high grief severity) show greater increases in blood pressure, and greater inflammatory response to a lab-based acute stressor than individuals with lower PG-13-R scores.[37] A systematic review reported an association between (typical and atypical) grief severity and immune biomarkers.[38] Finally, there are indications of differential patterns of transcription factor activation and gene expression involved in innate antiviral responses found in individuals with prolonged grief disorder versus typical grief, as compared with individuals who have not been bereaved.[38]

Diagnostic considerations

The diagnosis of prolonged grief disorder requires validated structured clinical interviews or self-report questionnaires.[39] The pursuit for recognised diagnostic criteria for prolonged grief disorder has led to various assessment measures. This summary provides recent research on prolonged grief disorder prevalence (using current and precursor definitions), comorbidity, differentiation from other mental health disorders, and the global applicability of the current prolonged grief disorder criteria. The assessment measures with the strongest evidence base to date are also presented.

Prevalence rates

Since their establishment, researchers have examined prolonged grief disorder prevalence using the newest ICD-11 and DSM-5-TR criteria. In a German representative bereaved sample, 30 (3%) of 914 individuals met prolonged grief disorder DSM-5-TR criteria, whereas 38 (4%) met ICD-11 criteria.[40] Thus, differences in the two diagnostic criteria minimally affect prevalence; however, sample representativeness does. Non-probability or convenience samples tend to show higher prevalence rates (16·0%) compared with probability samples, such as register-based samples (5·0%), as reported in a cross-national analysis.[41] Prolonged grief disorder rates are frequently higher in indicated samples and contexts, signifying its clinical utility and construct validity. For example, people who lost a partner or a child had a higher risk of developing prolonged grief disorder (complicated grief) compared with those who lost a parent or a sibling.[42] Much of the previous research in this area is based on descriptions of prolonged grief disorder that are slightly different from the current criteria in DSM-5-TR and ICD-11. Differences between the criteria are modest and although it is conceivable that findings based on early prolonged grief disorder descriptions are largely applicable to DSM-5-TR and ICD-11 based descriptions,[25] there are some discrepancies. Thus, future research using the DSM-5-TR and ICD-11 criteria should confirm the specific reliability and validity of measures, referencing these current official diagnostic algorithms to determine more precisely their comparability.

The inconsistency in assessment tools and different diagnostic algorithms have affected the reliability of results. In a representative community sample in the UK, prevalence was tested using two different diagnostic algorithms; the strict prolonged grief disorder ICD-11 diagnostic algorithm found a prevalence of 2·4%, whereas the moderate prolonged grief disorder ICD-11 diagnostic algorithm found 7·9%.[43] Agreement on the use of standardised assessment measures might help to resolve inconsistencies. Currently, there are several questionnaires and assessment measures in use, such as Traumatic Grief Inventory-Self Report Plus (TGI-SR+),[44] PG-13-R,[22,45] Inventory of Complicated Grief,[46] International Grief Questionnaire,[47] Aarhus PGD scale,[48] and the International Prolonged Grief Disorder Scale.[49] Of these measures, the TGI-SR+, Aarhus PGD scale, and PG-13-R measure both ICD-11 and DSM-5-TR prolonged grief disorder criteria sets. Several of these scales have been validated across various countries and cultures.[49,50] However, self-report questionnaires are not the gold standard for diagnosing mental health disorders. There was modest concordance between self-report questionnaires and structured clinical interviews, and self-report questionnaires often overestimated the occurrence of disorders.[51] Several structured clinical interviews based on the diagnostic criteria of ICD-11 and DSM-5-TR are in development and awaiting further validation.[52–54]

Comorbidity

Prolonged grief disorder exhibits a high comorbidity rate with depression and PTSD. A meta-analysis study indicated that the proportion of co-occurrence of prolonged grief reactions with other responses (eg, depression, anxiety, and PTSD symptoms) is higher than the proportion of standalone prolonged grief reactions.[55] Similarly, a large panel study involving 1529 bereaved individuals (1015 experiencing traumatic bereavement and 514 experiencing natural bereavement), producing data that closely approximate representative samples, found that 441 (28·8%) of 1529 of the bereaved reported at least two types of psychological disorders—ie, major depression, prolonged grief disorder (per DSM-5-TR criteria), or PTSD. Furthermore, of the 312 individuals who met the prolonged grief disorder diagnostic criteria, 82 (26·3%) also met the PTSD criteria, 24 (7·7%) met the depression criteria, and 180 (57·7%) met the criteria for both PTSD and depression. Only 26 (8·3%) individuals met the diagnostic criteria of prolonged grief disorder alone.[56] These findings highlight the importance of addressing comorbidity in intervention approaches. The substantial overlap in symptoms suggests that integrated therapeutic strategies might enhance treatment outcomes. For example, depressive symptoms were reduced when antidepressants were incorporated into prolonged grief disorder treatment.[57] Prolonged grief disorder-focused cognitive behavioural therapy (CBT) has been found to mitigate co-occurring bereavement-related depression and PTSD.[58]

Major differential diagnoses

Prolonged grief disorder versus PTSD

Although prolonged grief disorder and PTSD can both arise after a traumatic or unexpected loss,[59] they have distinct characteristics and diagnostic criteria. Both disorders involve intrusive thoughts related to the stressful life event.[60] Typical intrusions in prolonged grief disorder mirror separation distress (and thus typically relate to the relationship with the lost person), whereas in PTSD these mirror traumatic distress (and thus typically relate to threatening events surrounding the death),

although intrusions relating to the death event are also common in prolonged grief disorder.[61] In prolonged grief disorder, intrusive thoughts about the deceased close other, unlike their death, are often bittersweet and evoke heartache and missing of their loved one. Both conditions can elicit strong emotional reactions, such as sadness, anger, and guilt. The hallmark symptom of prolonged grief disorder is separation distress, which triggers intense yearning for the deceased person and excessive preoccupation of thoughts of the deceased person. PTSD is characterised by a sense of current threat brought on by re-experiencing symptoms and hyperarousal.[62] Research shows that overlapping cognitive behavioural processes (eg, poor memory integration, negative appraisals, and maladaptive coping strategies) influence the development and maintenance of both prolonged grief disorder and PTSD.[63] Conversely, factor analysis results indicate that symptoms of both conditions represent distinct factors.[64] Network analysis further supports this distinction, showing that symptoms of prolonged grief disorder and PTSD form two separate clusters.[65] Longitudinal research has shown that early prolonged grief disorder symptoms more strongly predict later instances of PTSD than vice versa.[66] However, the type of trauma exposure might alter this relationship, as seen in Utøya massacre survivors, where PTSD predicted prolonged grief disorder after 12 months.[67]

Prolonged grief disorder versus major depressive disorder

Core symptoms of major depressive disorder include low mood (dysphoria), lack of interest or enjoyment of usual activities, along with physical symptoms, such as fatigue and low energy. Cognitive and psychological variables also include difficulty concentrating, low self-esteem, feelings of guilt and hopelessness, and suicidal thoughts.[68] Central to the distinction between prolonged grief disorder and major depressive disorder is whether the symptoms relate to the loss of a close person. Although accessory prolonged grief disorder symptoms might overlap with symptoms of major depressive disorder (ie, dysphoria, guilt, anger, or hopelessness), in prolonged grief disorder these are directly related to the death of the close person.[69] In major depressive disorder, these symptoms are more globally focused, contributing to a sense of worthlessness, self-contempt, and hopelessness. Research using latent class analysis and network analysis has found clear distinction between major depressive disorder and prolonged grief disorder.[65,70] The distinctions between prolonged grief disorder, PTSD, and major depressive disorder have important implications for intervention. Lichtenthal and colleagues[34] showed that, compared with clinicians without prolonged grief disorder training, those who reviewed materials on prolonged grief disorder were more likely to recommend grief-specific interventions, such as attachment-focused emotion-focused therapy, and were less likely to recommend antidepressants.

Cultural and societal influences on prolonged grief disorder

Similarly to other mental disorders, the question of universality versus cultural specificity of symptoms is also relevant for prolonged grief disorder. Although culture substantially influences the experience and expression of mental health disorders, there might be universally common symptoms of disorder, linked to our shared human neurobiology[71] that occur regardless of culture and context.[72] Cultural considerations could increase the validity of a diagnosis. For instance, Indian widows residing in Fiji are expected to withdraw from social activities and limit contact with men (except close relatives), while focusing entirely on child-rearing and mourning, which frequently leads to depression-like symptoms. Without considering the circumstances and mourning traditions, it is possible that these women would meet criteria for a mental health disorder.[73] The recent diagnostic criteria of prolonged grief disorder yields a prevalence rate of zero of 301 Balinese individuals bereaved by a traffic accident.[74] The finding implied that Global North diagnostic standards might be inadequate to identify prolonged grief disorder in the Balinese population. Mental suffering following the loss of a close person could manifest in symptoms that are not assessed with existing Global North-based diagnostic tools.[75] This finding also suggests the potential protective function of distinct Balinese rituals, which are deeply integrated into Hindu religious practices and are underpinned by positive beliefs regarding death and the afterlife (eg, reincarnation and karma). Hindu funeral rituals, such as washing the body of the deceased and collecting the soul to be taken to different temples, aim to care for the deceased and help them transition from life to death. These rituals might also assist the bereaved in building a continuing bond with the deceased, and large-scale funeral ceremonies might enhance social support.[76] Research from other cultures (eg, Confucian traditions in China, South Korea, and Malaysia and Buddhism in Japan) has shown that rituals help the bereaved to establish a continuing connection with the deceased and strengthen social ties within their support system.[77,78] The existing studies are primarily qualitative explorations; future studies need to conduct more rigorous quantitative research to test these viewpoints.[79]

The COVID-19 pandemic provided a unique opportunity for researchers to examine how societal disruptions affect grieving processes across different cultural contexts. Studies conducted in the Netherlands and China[80,81] reported elevated rates of prolonged grief disorder compared with pre-pandemic norms. However, evidence from multiple samples suggests that the highest levels of grief severity during the pandemic were linked to unnatural losses, such as suicide, accidents, and homicide, rather than COVID-19-related deaths.[82,83] The effects of pandemic-related restrictions and disruptions to mourning rituals on grief severity remain

inconclusive, with some studies identifying significant associations whereas others did not.[84,85] Additionally, Harrop and colleagues[86] found that early social isolation and a lack of social support during bereavement were strong predictors of later prolonged grief disorder in people bereaved within the first year of the pandemic (measured at four time points in a longitudinal survey). These findings highlight the multifaceted nature of grief during the pandemic, shaped by the type of loss and the availability of social and cultural support systems.

Various approaches have been proposed to address the cultural factors relevant to diagnosing prolonged grief disorder. Some researchers have suggested incorporating simple, person-centred, open-ended semi-structured interviews,[87] such as the Bereavement and Grief Cultural Formulation Interview (BG-CFI), a supplement to the DSM-5-TR cultural formulation interview.[88] In addition, the Structured Clinical Interview for Prolonged Grief (SCIP) asks clinicians to rate whether symptoms might be better characterised as local customs or mourning rituals.[53] Other tools have been developed with culturally specific items.[89] Comparative studies involving bereaved samples across five countries (ie, Switzerland, China, Israel, Portugal, and Ireland) have shown that the prevalence of prolonged grief disorder varies by country, even using the same measures. These findings suggest that supplementing standardised diagnostic criteria (ie, ICD-11 or DSM-5-TR) with culturally specific items could improve treatment planning in different cultural contexts.[36,90] However, there is no consensus on how best to incorporate cultural factors into prolonged grief disorder diagnosis, and large-scale cross-national studies could help balance universality and specificity.

By comparing these global and historical disruptions with culturally specific practices, it becomes evident that grief is not only shaped by traditions, but is also profoundly affected by the availability—or absence—of social and emotional support systems during times of loss. This dual influence of culture and external societal factors necessitates further exploration to better address grief in diverse contexts.

Cause and theories of grief

Causal theories of prolonged grief disorder span bio-psychosocial levels of explanation. The role of attachment in prolonged grief disorder has been explored historically in psychoanalytic theory and has gained more recent behavioural and neurobiological evidence. Freud's *Mourning and Melancholia* (1917) introduced the concept of grief work, where individuals gradually detach from the close person, allowing for new attachments.[91] According to Freud, reactions to loss could either manifest as mourning (a healthy, adaptive process) or melancholia (a destabilising and chronic condition). In the 1960s, Bowlby proposed that attachment promotes safety and survival, and pathological grief arises from the inability to reconnect with others, paired with persistent yearning for the deceased.[92] In the 1990s, models of typical bereavement, such as the dual process model and the two track model of bereavement, were introduced.[93,94] Empirical validation of these models in the context of PGD is required. In the 2000s, Shear and colleagues[95] suggested that prolonged grief stems from a mismatch between the reality of the death and the mental representation of an attachment figure as being emotionally and physically available, where successful adaptation relies on forming an enduring psychological connection with the deceased.[96] Maccallum and Bryant[97] linked mourning to revisions in the self-memory system, arguing that prolonged grief disorder arises when the individual's self-identity, deeply entwined with the deceased, is disrupted. This disturbance impairs the integration of loss into autobiographical memory, leading to emotional and cognitive difficulties. Although grief is a reaction to a social loss, it has been viewed almost exclusively through the lens of individual psychology and not sociology. Maciejewski and colleages[98] advocate for a complementary sociological perspective. They propose bereavement as a state of social deprivation (eg, role confusion and social disconnection) and emphasise that addressing such deprivations, such as by enhancing social connections, can reduce distress and promote adaptation to loss, a view that is gaining empirical support.[99] Grief does not just affect the individual, but also the family system as well as the community.[100] This framing is particularly profound in the case of natural or manmade disasters where collective grief and mourning might perpetuate symptoms of grief. However, the shared experience and understanding of loss might provide solace and support.[101] The role of community support, social acknowledgment, collective traditions, and rituals on bereavement outcomes and prolonged grief disorder is an emerging area of interest for both clinicians and researchers.[102]

Cognitive behavioural model of prolonged grief disorder

The cognitive behavioural conceptualisation of prolonged grief disorder suggests three mechanisms perpetuating prolonged grief disorder symptoms.[103]

First, insufficient integration of knowledge about the irreversibility of the loss into autobiographical knowledge about the self and the relationship with the lost person.

Second, maladaptive beliefs about the self, life, and the future, along with misinterpretations of grief reactions.

Third, avoidance behaviours that can be anxious (eg, avoiding reminders of the loss) or depressive (eg, withdrawing from potentially adaptive activities).

A systematic review found strong evidence that emotion regulation strategies, such as rumination and experiential avoidance, are also central to the persistence and treatment of prolonged grief disorder.[104] Empirical research has characterised these mechanisms and shown them to be clinically important in the development and maintenance of prolonged grief disorder.[105] In a three-wave longitudinal study, Smith and colleagues[106]

found that grief-related memory characteristics, which include intrusiveness, visceral consequences, and triggers of loss memories, their tendency to be negative in nature or emotion—even when the memories were objectively pleasant—along with avoidant, proximity-seeking, and ruminative coping strategies predicted later prolonged grief disorder. These predictions held after controlling for baseline symptoms and autocorrelations.[107] This evidence suggests, in line with the CBT model, that targeting these mechanisms in treatment is likely to resolve prolonged grief disorder symptoms.

Neurobiological theory

The gone-but-also-everlasting theory[108] combines attachment theory and cognitive neuroscience to suggest that grieving can be seen as a form of learning over time, as the internal representation of the deceased is updated from "everlasting" to "gone". Attachment and the subsequent separation distress after death can be mapped onto neurobiological architecture. While the close person is alive, the initial intimate bond (or attachment) is encoded in neurological pathways that predictively anticipate the return of the attachment figure, even when they are not present.[108] During separation, the bereaved might implicitly believe that the close person continues to exist despite their absence, serving an important evolutionary function for safety and security. Neurohormones, such as oxytocin and dopamine, which are part of the reward-related pathway, are released on reunion. After a close person's death, the brain must update the previously encoded attachment and reward-related pathways with new information regarding their absence.[108] Based on real-time feedback, the brain relearns the world without the close person.[109] A review and subsequent follow-up studies confirm that patients with prolonged grief disorder have a differential activation of the reward network and altered oxytocin signalling.[38,110]

Treatment and interventions

A tiered approach to bereavement care, which allocates services based on need and acknowledges the limited resources of health-care systems, has long been recommended.[111] Bereavement support is often underfunded and overlooked in community and health-care settings despite guidelines such as: printed psychoeducation for low-risk individuals; community groups and trained volunteer support for at-risk individuals; and specialist support for high-risk groups, including people with prolonged grief disorder.[112,113] Research consistently shows that targeted psychological therapies effectively relieve distress and aid adaptation in individuals with prolonged grief disorder.[114]

Numerous randomised controlled trials on prolonged grief treatment (previously complicated grief treatment) report statistically significant and sustained effects on prolonged grief disorder symptoms.[57] Most studies have focused on variations of CBT, which emphasises the interplay of memories, negative beliefs, and maladaptive coping behaviours to reduce emotional suffering.[115] Other psychological treatment approaches, such as eye movement desensitisation, reprocessing and compassion-focused therapy, and mindfulness, have yet to prove efficacious.[116–118] Key components of successful therapeutics include the role of exposure to avoided stimulus (eg, memories and situations) in creating meaningful change.[119,120] However, a recent meta-analysis comparing CBT with and without exposure did not support an enhanced effect of exposure, although further research is needed due to the small number of studies available for comparison.[121]

Within the past 20 years, preventive approaches for prolonged grief disorder generally showed inconsistent efficacy.[122] Encouragingly, more recent studies have found success with interventions tailored to specific contexts.[123] Approaches based on CBT principles have shown effectiveness in both guided[124] and unguided formats.[125] Additionally, alternative methods, such as systemic family therapy within cancer care for at-risk families, both before and after the death, significantly reduced rates of prolonged grief disorder at 6 months.[126] Kentish-Barnes and colleages[127] conducted three meetings with family members of patients dying in intensive care units—two before the death and one after—to provide education, support, and closure. These cases highlight that well timed, context-specific interventions can effectively prevent prolonged grief disorder or prevent it from becoming chronic.

Pharmacological interventions remain underexplored, with only one randomised controlled trial to date examining the role of the selective serotonin reuptake inhibitor, citalopram, alongside psychological therapy. This study observed that, although depressive symptoms decreased when antidepressants were added to prolonged grief disorder treatment, no additive therapeutic effects of the drug in combination with therapy were found for grief symptoms[57] and increased dropout was observed in some groups (eg, individuals who were suicide-bereaved) when it was administered in isolation.[128] New research is emerging exploring the neurobiological underpinnings of prolonged grief disorder and the potential of psychopharmacological intervention. However, the call for responsible use is essential.[129]

Some demographic groups, including minority ethnic populations in predominantly White countries and individuals with low socioeconomic status, face disparities in accessing mental health care for prolonged grief disorder. Similarly, culturally tailored interventions that acknowledge and address unique cultural beliefs and practices surrounding grief are essential to ensure equitable care.[130] Although CBT approaches for prolonged grief disorder have been shown to be applicable in non-Global North cultures and effective in non-White populations, further research is needed.[131] A challenge for the field is understanding how to administer treatment

to at-risk populations in challenging conditions. A trial of a brief (5-week) group-based approach in Syrian refugees and their children showed no significant effect on prolonged grief disorder, although meeting the criteria for the disorder was not an inclusion criterion for the trial.[132] Conversely, a recent randomised controlled trial with Myanmar refugees in Malaysia found significant moderate effects on prolonged grief disorder using CBT and integrative adapt therapy (ie, an approach that recognises the psychosocial disruptions caused by mass conflict and displacement).[133]

Given the challenges of implementation, scalable interventions offer promising avenues for expanding access to prolonged grief disorder treatment. Internet-based interventions provide flexibility and convenience, overcoming barriers such as geographical constraints and stigma. Treatment effects of guided and unguided digital approaches appear comparable and moderate to large,[134] although unguided approaches seem to suffer from high dropout rates.[105] The scalability of digital interventions holds promise for reaching underserved populations with limited access to traditional mental health services.

Children and adolescents grieving the loss of a close person require specialised support tailored to their developmental needs.[135] CBT has been shown to be effective in both Global North and non-Global North populations, delivered in group formats,[136] suggesting its broad applicability across different cultural contexts. There is also evidence for family-based approaches that emphasise enhanced coping skills, emotional regulation, and peer support,[137] which have been shown to have a long-term effect on suicidal behaviours.[138] Overall, although the evidence base is still growing, current findings support the use of specialised CBT and family-based approaches to effectively treat prolonged grief disorder in young people.

Search strategy and selection criteria

We searched PubMed, PsychINFO, Web of Science, and Embase for peer reviewed published research articles on prolonged grief disorder from database inception until January, 2025. As the latest definition of prolonged grief disorder was only introduced in 2018 for the International Classification of Diseases, 11th edition, and in 2022 for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, to ensure the inclusion of all relevant sources, the following search terms were used: "prolonged grief disorder" or "complicated grief" or "persistent complex bereavement disorder" or "prolonged grief" or "disturbed grief". These terms include both current conceptualisations of prolonged grief disorder and previous iterations. For clarity throughout the Review, we have indicated which prolonged grief disorder iteration is used in the supporting research study. Primary studies, as well as a small number of reviews, meta-analyses, and randomised controlled trials comprise the main sources for this Review. There were no restrictions on language.

Future directions

The field of prolonged grief disorder research is expanding rapidly and new research on the refinement of diagnostic items, inclusion of cultural features, and timing of diagnosis is progressing at a fast pace.[139] The treatment landscape for prolonged grief disorder is evolving, with a diverse array of interventions aimed at addressing the complex needs of individuals with pathological grief reactions. Psychotherapeutic interventions, including CBT and specialised grief therapies, remain foundational in prolonged grief disorder treatment. However, emerging modalities, such as scalable digital platforms, offer promising avenues for expanding access to effective prolonged grief disorder care. Furthermore, targeted support for underserved populations, children, and adolescents is essential for ensuring equitable access to quality prolonged grief disorder interventions and improving outcomes for individuals navigating loss. Alternative treatment options, including homegrown solutions in different world regions and cultures are also emerging.[140] With ongoing conflicts in Sudan, Ukraine, and the Middle East, culturally appropriate and effective prolonged grief disorder treatments are urgently needed in an accessible format. Researchers and clinicians need to work with public health agents to improve options for preventive care, working towards a comprehensive stepped or tiered model.

Conclusion

Grief is a universal experience. However, for a minority of individuals, grief becomes a debilitating, devastating mental health disorder with serious implications on a personal and societal level. Prolonged grief disorder presents the opportunity for worldwide recognition that grief can become a debilitating mental health disorder. As defined by WHO, mental health is "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community".[141] Prolonged grief disorder represents a deviation from stable healthy functioning and deserves research support, evidence-based treatments, and funding for improved psychosocial support.[142] Future research is needed to determine the role of cultural, social, and geographical influences on the severity and course of grief and to confirm the timing and duration of grief to correctly diagnose and validate prolonged grief disorder in specific subgroups of people.

Contributors

CK, KVS, and NZ are responsible for writing of the original draft. HGP, M-FO, CKK-K, and PAB are responsible for writing, review, and editing of the manuscript. AM is responsible for early drafting, writing, review, and editing.

Declaration of interests
CK is supported by the Swiss National Science Foundation Starting Grant (TMSGI1_218018). KVS is supported by the Medical Research Council (MR/V001841/1) and the National Institute for Health and Care Research (NIHR) Oxford Health Biomedical Research Centre (NIHR203316). HGP is supported by the National Cancer Institute (CA197730). All other authors declare no competing interests. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Acknowledgments
The authors thank Eva Stelzer for her assistance with this Review.

References

1 American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition, text revision. American Psychiatric Association, 2022.
2 WHO. ICD-11 for mortality and morbidity statistics. WHO, 2020.
3 American Psychiatric Association. Diagnostic and statistical manual of mental disorders, third edition. American Psychiatric Association, 1980.
4 American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition. American Psychiatric Association, 2013.
5 Shear MK, Wang Y, Skritskaya N, Duan N, Mauro C, Ghesquiere A. Treatment of complicated grief in elderly persons: a randomized clinical trial. *JAMA Psychiatry* 2014; **71:** 1287–95.
6 Prigerson HG, Kakarala S, Gang J, Maciejewski PK. History and status of prolonged grief disorder as a psychiatric diagnosis. *Annu Rev Clin Psychol* 2021; **17:** 109–26.
7 Prigerson HG, Singer J, Killikelly C. Prolonged grief disorder: addressing misconceptions with evidence. *Am J Geriatr Psychiatry* 2024; **32:** 527–34.
8 Cacciatore J, Francis A. DSM-5-TR turns normal grief into a mental disorder. *Lancet Psychiatry* 2022; **9:** e32.
9 Bergsmark LPS, Ramsing F. Which considerations are lost when debating the prolonged grief disorder diagnosis? *Theory Psychol* 2023; **33:** 856–72.
10 Brinkmann S. Diagnostic cultures: a cultural approach to the pathologization of modern life. Routledge, 2016.
11 Ratcliffe M. Grief worlds: a study of emotional experience. MIT Press, 2023.
12 Brinkmann S. Could grief be a mental disorder? *Nord Psychol* 2018; **70:** 146–59.
13 Brinkmann S. The grieving animal: grief as a foundational emotion. *Theory Psychol* 2018; **28:** 193–207.
14 Bandini J. The medicalization of bereavement: (ab)normal grief in the DSM-5. *Death Stud* 2015; **39:** 347–52.
15 Thieleman K, Cacciatore J, Frances A. Rates of prolonged grief disorder: considering relationship to the person who died and cause of death. *J Affect Disord* 2023; **339:** 832–37.
16 Kessler RC, Aguilar-Gaxiola S, Alonso J, et al. Trauma and PTSD in the WHO world mental health surveys. *Eur J Psychotraumatol* 2017; **8**(suppl 5)**:** 1353383.
17 Morgan DL. Paradigms lost and pragmatism regained: methodological implications of combining qualitative and quantitative methods. *J Mixed Methods Res* 2007; **1:** 48–76.
18 Aftab A. Conceptual psychiatry: the ground beneath our feet. *Int Rev Psychiatry* 2021; **33:** 443–45.
19 Horowitz M, Siegel B, Holen A. Bonanno GA, Milbrath C, Stinson CH. Diagnostic criteria for complicated grief. *Am J Psychiatry* 2015; **1997:** 904–10.
20 Killikelly C, Maercker A. Prolonged grief disorder for ICD-11: the primacy of clinical utility and international applicability. *Eur J Psychotraumatol* 2018; **8** (suppl 6)**:** 1476441.
21 Haneveld J, Rosner R, Vogel A, et al. Same name, same content? Evaluation of DSM-5-TR and ICD-11 prolonged grief criteria. *J Consult Clin Psychol* 2022; **90:** 303–13.
22 Prigerson H, Horowitz MJ, Jacobs SC, et al. Prolonged grief disorder: psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Med* 2009; **6:** e1000121.
23 Shear MK, Simon N, Wall M, et al. Complicated grief and related bereavement issues for DSM-5. *Depress Anxiety* 2011; **28:** 103–17.
24 Maercker A, Brewin CR, Bryant RA, et al. Diagnosis and classification of disorders specifically associated with stress: proposals for ICD-11. *World Psychiatry* 2013; **12:** 198–206.
25 Boelen PA, Lenferink LIM. Comparison of six proposed diagnostic criteria sets for disturbed grief. *Psychiatry Res* 2020; **285:** 112786.
26 Mazza A, Maercker A, Forstmeier S, Muller M, Killikelly C. Towards centrality evaluation of yearning symptoms for prolonged grief disorder: a cross-cultural approach. *Psychopathology* 2024; **10:** 1–11.
27 Galatzer-Levy IR, Huang SH, Bonanno GA. Trajectories of resilience and dysfunction following potential trauma: a review and statistical evaluation. *Clin Psychol Rev* 2018; **63:** 41–55.
28 Djelantik AAAMJ, Robinaugh DJ, Boelen PA. The course of symptoms in the first 27 months following bereavement: a latent trajectory analysis of prolonged grief, posttraumatic stress, and depression. *Psychiatry Res* 2022; **311:** 114472.
29 Maciejewski PK, Maercker A, Boelen PA, Prigerson HG. "Prolonged grief disorder" and "persistent complex bereavement disorder", but not "complicated grief", are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. *World Psychiatry* 2016; **15:** 266–75.
30 Holland JM, Neimeyer RA, Boelen PA, Prigerson HG. The underlying structure of grief: a taxometric investigation of prolonged and normal reactions to loss. *J Psychopathol Behav Assess* 2009; **31:** 190–201.
31 Killikelly C, Smid GE, Wagner B, Boelen PA. Responding to the new International Classification of Diseases-11 prolonged grief disorder during the COVID-19 pandemic: a new bereavement network and three-tiered model of care. *Public Health* 2021; **191:** 85–90.
32 Aoun SM, Breen LJ, Howting DA, Rumbold B, McNamara B, Hegney D. Who needs bereavement support? A population based survey of bereavement risk and support need. *PLoS One* 2015; **10:** e0121101.
33 Keeley JW, Reed GM, Roberts MC, et al. Developing a science of clinical utility in diagnostic classification systems field study strategies for ICD-11 mental and behavioral disorders. *Am Psychol* 2016; **71:** 3–16.
34 Lichtenthal WG, Maciejewski PK, Craig Demirjian C, et al. Evidence of the clinical utility of a prolonged grief disorder diagnosis. *World Psychiatry* 2018; **17:** 364–65.
35 Cozza SJ, Fisher JE, Mauro C, et al. Performance of DSM-5 persistent complex bereavement disorder criteria in a community sample of bereaved military family members. *Am J Psychiatry* 2016; **173:** 919–29.
36 Killikelly C, Kagialis A, Henneman S, et al. Measurement and assessment of grief in a large international sample. *J Affect Disord* 2023; **327:** 306–14.
37 Palitsky R, Wilson DT, Friedman SE, Ruiz JM, Sullivan D, O'Connor MF. The relationship of prolonged grief disorder symptoms with hemodynamic response to grief recall among bereaved adults. *Psychosom Med* 2023; **85:** 545–50.
38 Knowles LM, Ruiz JM, O'Connor MF. A systematic review of the association between bereavement and biomarkers of immune function. *Psychosom Med* 2019; **81:** 415–33.
39 Stroebe MS, Schut HAW, Eisma MC. On the classification and reporting of prolonged grief: assessment and research guidelines. *Harv Rev Psychiatry* 2024; **32:** 15–32.
40 Rosner R, Comtesse H, Vogel A, Doering BK. Prevalence of prolonged grief disorder. *J Affect Disord* 2021; **287:** 301–07.
41 Comtesse H, Smid GE, Rummel AM, Spreeuwenberg P, Lundorff M, Dückers MLA. Cross-national analysis of the prevalence of prolonged grief disorder. *J Affect Disord* 2024; **350:** 359–65.
42 Kersting A, Brähler E, Glaesmer H, Wagner B. Prevalence of complicated grief in a representative population-based sample. *J Affect Disord* 2011; **131:** 339–43.
43 Shevlin M, Redican E, Hyland P, et al. Symptoms and levels of ICD-11 prolonged grief disorder in a representative community sample of UK adults. *Soc Psychiatry Psychiatr Epidemiol* 2023; **58:** 1535–47.
44 Lenferink LIM, Eisma MC, Smid GE, de Keijser J, Boelen PA. Valid measurement of DSM-5 persistent complex bereavement disorder and DSM-5-TR and ICD-11 prolonged grief disorder: the Traumatic Grief Inventory-Self Report Plus (TGI-SR+). *Compr Psychiatry* 2022; **112:** 152281.

45 Prigerson HG, Boelen PA, Xu J, Smith KV, Maciejewski PK. Validation of the new DSM-5-TR criteria for prolonged grief disorder and the PG-13-Revised (PG-13-R) scale. *World Psychiatry* 2021; **20:** 96–106.

46 Prigerson HG, Maciejewski PK, Reynolds CF 3rd, et al. Inventory of complicated grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Res* 1995; **59:** 65–79.

47 Hyland P, Redican E, Karatzias T, Shevlin M. The international grief questionnaire (IGQ): a new measure of ICD-11 prolonged grief disorder. *J Trauma Stress* 2024; **37:** 141–53.

48 O'Connor M, Vang ML, Shevlin M, et al. Development and validation of the Aarhus PGD scale for operationalizing ICD-11 and DSM-5-TR prolonged grief disorder. *J Affect Disord* 2023; **342:** 201–09.

49 Killikelly C, Zhou N, Merzhvynska M, et al. Development of the international prolonged grief disorder scale for the ICD-11: measurement of core symptoms and culture items adapted for Chinese and German-speaking samples. *J Affect Disord* 2020; **277:** 568–76.

50 Kokou-Kpolou CK, Lenferink LIM, Brunnet AE, et al. The ICD-11 and DSM-5-TR prolonged grief criteria: validation of the traumatic grief inventory-self report plus using exploratory factor analysis and item response theory. *Clin Psychol Psychother* 2022; **29:** 1950–62.

51 Bui E, Mauro C, Robinaugh DJ, et al. The structured clinical interview for complicated grief: reliability, validity, and exploratory factor analysis. *Depress Anxiety* 2015; **32:** 485–92.

52 Rueger MS, Lechner-Meichsner F, Kirschbaum L, Lubik S, Roll SC, Steil R. Prolonged grief disorder in an inpatient psychiatric sample: psychometric properties of a new clinical interview and preliminary prevalence. *BMC Psychiatry* 2024; **24:** 333.

53 Maciejewski PK, Prigerson HG. Part II: chapter 4: defining and diagnosing PGD. In: Reynolds C, Cozza S, Maciejewski P, et al, eds. Grief and prolonged grief disorder. American Psychiatric Association, 2024, 79–107.

54 O'Connor M, Larsen L, Joensen BV, et al. Valid ICD-11 PGD scales and structured clinical interviews needed. *Front Psychol* 2020; **11:** 1120.

55 Komischke-Konnerup KB, Zachariae R, Johannsen M, Nielsen LD, O'Connor M. Co-occurrence of prolonged grief symptoms and symptoms of depression, anxiety, and posttraumatic stress in bereaved adults: a systematic review and meta-analysis. *J Affect Disord Rep* 2021; **4:** 100140.

56 Rheingold AA, Williams JL, Bottomley JS. Prevalence and co-occurrence of psychiatric conditions among bereaved adults. *JAMA Netw Open* 2024; **7:** e2415325.

57 Shear MK, Reynolds CF 3rd, Simon NM, et al. Optimizing treatment of complicated grief: a randomized clinical trial. *JAMA Psychiatry* 2016; **73:** 685–94.

58 Komischke-Konnerup KB, O'Connor M, Hoijtink H, Boelen PA. Cognitive-behavioral therapy for complicated grief reactions: treatment protocol and preliminary findings from a naturalistic setting. *Cognit Behav Prac* 2025; **32:** 29–43.

59 Atwoli L, Stein DJ, King A, et al. Posttraumatic stress disorder associated with unexpected death of a loved one: cross-national findings from the world mental health surveys. *Depress Anxiety* 2017; **34:** 315–26.

60 Kokou-Kpolou CK, Moukouta CS, Masson J, Bernoussi A, Cénat JM, Bacqué MF. Correlates of grief-related disorders and mental health outcomes among adult refugees exposed to trauma and bereavement: a systematic review and future research directions. *J Affect Disord* 2020; **267:** 171–84.

61 Boelen PA, Huntjens RJC. Intrusive images in grief: an exploratory study. *Clin Psychol Psychother* 2008; **15:** 217–26.

62 Ehlers A, Clark DM. A cognitive model of posttraumatic stress disorder. *Behav Res Ther* 2000; **38:** 319–45.

63 Smith K V, Ehlers A. Prolonged grief and posttraumatic stress disorder following the loss of a significant other: an investigation of cognitive and behavioural differences. *PLoS One* 2021; **16:** e0248852.

64 Boelen PA, van de Schoot R, van den Hout MA, de Keijser J, van den Bout J. Prolonged grief disorder, depression, and posttraumatic stress disorder are distinguishable syndromes. *J Affect Disord* 2010; **125:** 374–78.

65 Djelantik AAAMJ, Robinaugh DJ, Kleber RJ, Smid GE, Boelen PA. Symptomatology following loss and trauma: latent class and network analyses of prolonged grief disorder, posttraumatic stress disorder, and depression in a treatment-seeking trauma-exposed sample. *Depress Anxiety* 2020; **37:** 26–34.

66 Lenferink LIM, Nickerson A, de Keijser J, Smid GE, Boelen PA. Reciprocal associations among symptom levels of disturbed grief, posttraumatic stress, and depression following traumatic loss: a four-wave cross-lagged study. *Clin Psychol Sci* 2019; **7:** 1330–39.

67 Glad KA, Stensland S, Czajkowski NO, Boelen PA, Dyb G. The longitudinal association between symptoms of posttraumatic stress and complicated grief: a random intercepts cross-lag analysis. *Psychol Trauma* 2022; **14:** 386–92.

68 Kersting A, Kroker K, Horstmann J, et al. Complicated grief in patients with unipolar depression. *J Affect Disord* 2009; **118:** 201–04.

69 Boelen PA, de Keijser J, Smid G. Cognitive-behavioral variables mediate the impact of violent loss on post-loss psychopathology. *Psychol Trauma* 2015; **7:** 382–90

70 Boelen PA, Lenferink LI. Symptoms of prolonged grief, posttraumatic stress, and depression in recently bereaved people: symptom profiles, predictive value, and cognitive behavioural correlates. *Soc Psychiatry Psychiatr Epidemiol* 2020; **55:** 765–77.

71 Kakarala SE, Roberts KE, Rogers M, et al. The neurobiological reward system in prolonged grief disorder (PGD): a systematic review. *Psychiatry Res Neuroimaging* 2020; **303:** 111135.

72 Stelzer EM, Höltge J, Zhou N, Maercker A, Killikelly C. Cross-cultural generalizability of the ICD-11 PGD symptom network: Identification of central symptoms and culturally specific items across German-speaking and Chinese bereaved. *Compr Psychiatry* 2020; **103:** 152211.

73 Tseng W. Culture and psychopathology: general view. In: Bhugra D, Bhui K, eds. Textbook of cultural psychiatry. Cambridge University Press, 2007, 95–112.

74 Djelantik AAAMJ, Aryani P, Boelen PA, Lesmana CBJ, Kleber RJ. Prolonged grief disorder, posttraumatic stress disorder, and depression following traffic accidents among bereaved Balinese family members: prevalence, latent classes and cultural correlates. *J Affect Disord* 2021; **292:** 773–81.

75 Kokou-Kpolou CK. Letter to the Editor: Prolonged grief disorder, posttraumatic stress disorder, and depression following traffic accidents among bereaved Balinese family members: prevalence, latent classes and cultural correlates. *J Affect Disord* 2021; **295:** 1–2.

76 Ghosh B, Athira BK. From ritual mourning to solitary grief: reinterpretation of Hindu death rituals in India. *Omega* 2022; **89:** 759–76.

77 Park S, Jang MK, Seo YJ, Doorenbos AZ. Funeral experience in South Korea: a phenomenological study. *Omega* 2022; **84:** 1025–44.

78 Chan CLW, Chow AYM, Ho SMY, et al. The experience of Chinese bereaved persons: a preliminary study of meaning making and continuing bonds. *Death Stud* 2005; **29:** 923–47.

79 Le HH, Ribeiro MPP, Killikelly C. The role of Vietnamese mourning culture in grief symptomatology—a study protocol. *Grief* 2025; **2:** 1–26.

80 Tang S, Xiang Z. Who suffered most after deaths due to COVID-19? Prevalence and correlates of prolonged grief disorder in COVID-19 related bereaved adults. *Global Health* 2021; **17:** 19.

81 Eisma MC, Tamminga A. Grief before and during the COVID-19 pandemic: multiple group comparisons. *J Pain Symptom Manage* 2020; **60:** e1–4.

82 Gang J, Falzarano F, She WJ, Winoker H, Prigerson HG. Are deaths from COVID-19 associated with higher rates of prolonged grief disorder (PGD) than deaths from other causes? *Death Stud* 2022; **46:** 1287–96.

83 Eisma MC, Tamminga A, Smid GE, Boelen PA. Acute grief after deaths due to COVID-19, natural causes and unnatural causes: an empirical comparison. *J Affect Disord* 2021; **278:** 54–56.

84 Schneider S, Rerick PO, Cummings C, McLean E, Breen LJ, Singer J. Pandemic grief risk factors and prolonged grief disorder in bereaved young adults during COVID-19. *Palliat Support Care* 2023; **21:** 836–42.

85 Mitima-Verloop HB, Mooren TTM, Kritikou ME, Boelen PA. Restricted mourning: impact of the COVID-19 pandemic on funeral services, grief rituals, and prolonged grief symptoms. *Front Psychiatry* 2022; **13:** 878818.

86 Harrop E, Medeiros Mirra R, Goss S, et al. Prolonged grief during and beyond the pandemic: factors associated with levels of grief in a four time-point longitudinal survey of people bereaved in the first year of the COVID-19 pandemic. *Front Public Health* 2023; **11:** 1215881.

87 Smid GE, Groen S, de la Rie SM, Kooper S, Boelen PA. Toward cultural assessment of grief and grief-related psychopathology. *Psychiatr Serv* 2018; **69:** 1050–52.

88 Groen SPN, Menninga CM, Daniëlle CC, Geert ES. Let's talk about grief: protocol of a study on the recognition and psychoeducation of prolonged grief disorder in outpatients with common mental disorders. *Front Psychiatry* 2022; **13:** 944233.

89 Killikelly C, Maercker A. The cultural supplement: a new method for assessing culturally relevant prolonged grief disorder symptoms. *Clin Psychol Eur* 2023; **5:** e7655.

90 Killikelly C, Merzhvynska M, Zhou N, et al. Examination of the new ICD-11 prolonged grief disorder guidelines across five international samples. *Clin Psychol Eur* 2021; **3:** e4159.

91 Freud S. Trauer Und Melancholie. *Int J Psychoanal* 1917; **4:** 288–301 (in German).

92 Bowlby J. Attachment and loss—volume I—attachment. 1969.

93 Rubin SS. The two-track model of bereavement: overview, retrospect, and prospect. *Death Stud* 1999; **23:** 681–714.

94 Stroebe M, Schut H. The dual process model of coping with bereavement: rationale and description. *Death Stud* 1999; **23:** 197–224.

95 Shear K, Monk T, Houck P, et al. An attachment-based model of complicated grief including the role of avoidance. *Eur Arch Psychiatry Clin Neurosci* 2007; **257:** 453–61.

96 Rubin SS, Malkinson R, Witztum E. Traumatic bereavements: rebalancing the relationship to the deceased and the death story using the two-track model of bereavement. *Front Psychiatry* 2020; **11:** 537596.

97 Maccallum F, Bryant RA. A cognitive attachment model of prolonged grief: integrating attachments, memory, and identity. *Clin Psychol Rev* 2013; **33:** 713–27.

98 Maciejewski PK, Falzarano FB, She WJ, Lichtenthal WG, Prigerson HG. A micro-sociological theory of adjustment to loss. *Curr Opin Psychol* 2022; **43:** 96–101.

99 Smith KV, Wild J, Ehlers A. The masking of mourning: social disconnection after bereavement and its role in psychological distress. *Clin Psychol Sci* 2020; **8:** 464–76.

100 Rubin SS, Malkinson R, Witztum E. Working with the bereaved: multiple lenses on loss and mourning. Taylor and Francis; 2012.

101 Franco MH, Malkinson R. Grief following mass tragedy. In: Servaty-Seib HL, Chapple HS, eds. Handbook of thanatology. The essential body of knowledge for the study of death, dying, and bereavement, 2021: 417–40.

102 Yehene E, Ohayon S, Yahav A, Levine H. Collective ambiguous loss after mass hostage-taking in war: exploring public mental health outcomes and resilience. *Eur J Psychotraumatol* 2024; **15:** 2434313.

103 Boelen PA, van den Hout MA, van den Bout J. A cognitive-behavioral conceptualization of complicated grief. *Clin Psychol* 2006; **13:** 109–28.

104 Eisma MC, Stroebe MS. Emotion regulatory strategies in complicated grief: a systematic review. *Behav Ther* 2021; **52:** 234–49.

105 Eisma MC, Boelen PA, van den Bout J, et al. Internet-based exposure and behavioral activation for complicated grief and rumination: a randomized controlled trial. *Behav Ther* 2015; **46:** 729–48.

106 Smith KV, Wild J, Ehlers A. Psychometric characteristics of the Oxford grief memory characteristics scale and its relationship with symptoms of ICD-11 and DSM-5-TR prolonged grief disorder. *Front Psychiatry* 2022; **13:** 814171.

107 Smith KV, Wild J, Ehlers A. From loss to disorder: the influence of maladaptive coping on prolonged grief. *Psychiatry Res* 2024; **339:** 116060.

108 O'Connor MF, Seeley SH. Grieving as a form of learning: insights from neuroscience applied to grief and loss. *Curr Opin Psychol* 2022; **43:** 317–22.

109 Boddez Y. The presence of your absence: a conditioning theory of grief. *Behav Res Ther* 2018; **106:** 18–27.

110 Arizmendi BJ, Seeley SH, Allen JJB, et al. A pull to be close: the differentiating effects of oxytocin and grief stimulus type on approach behavior in complicated grief. *Eur J Trauma Dissociation* 2023; **7:** 100339.

111 Aoun SM, Breen LJ, O'Connor M, Rumbold B, Nordstrom C. A public health approach to bereavement support services in palliative care. *Aust N Z J Public Health* 2012; **36:** 14–16.

112 Sallnow L, Smith R, Ahmedzai SH, et al. Report of the *Lancet* Commission on the value of death: bringing death back into life. *Lancet* 2022; **399:** 837–84.

113 Currier JM, Neimeyer RA, & Berman JS. The effectiveness of psychotherapeutic interventions for bereaved persons: a comprehensive quantitative review. Psychol Bull 2008; **134:** 648–61.

114 Johannsen M, Damholdt MF, Zachariae R, Lundorff M, Farver-Vestergaard I, O'Connor M. Psychological interventions for grief in adults: a systematic review and meta-analysis of randomized controlled trials. *J Affect Disord* 2019; **253:** 69–86.

115 Rosner R, Rau J, Kersting A, et al. Grief-specific cognitive behavioral therapy *vs* present-centered therapy: a randomized clinical trial. *JAMA Psychiatry* 2025; **82:** 109–117.

116 Bryant RA, Azevedo S, Yadav S, et al. Cognitive behavior therapy vs mindfulness in treatment of prolonged grief disorder: a randomized clinical trial. *JAMA Psychiatry* 2024; **81:** 646–54.

117 Johannsen M, Schlander C, Farver-Vestergaard I, et al. Group-based compassion-focused therapy for prolonged grief symptoms in adults—results from a randomized controlled trial. *Psychiatry Res* 2022; **314:** 114683.

118 Lenferink LIM, de Keijser J, Smid GE, Boelen PA. Cognitive therapy and EMDR for reducing psychopathology in bereaved people after the MH17 plane crash: findings from a randomized controlled trial. *Traumatology* 2020; **26:** 427–37.

119 Boelen PA, de Keijser J, van den Hout MA, van den Bout J. Treatment of complicated grief: a comparison between cognitive-behavioral therapy and supportive counseling. *J Consult Clin Psychol* 2007; **75:** 277–84.

120 Bryant RA, Kenny L, Joscelyne A, et al. Treating prolonged grief disorder: a randomized clinical trial. *JAMA Psychiatry* 2014; **71:** 1332–39.

121 Komischke-Konnerup KB, Zachariae R, Boelen PA, Marello MM, O'Connor M. Grief-focused cognitive behavioral therapies for prolonged grief symptoms: a systematic review and meta-analysis. *J Consult Clin Psychol* 2024; **92:** 236–48.

122 Wittouck C, Van Autreve S, De Jaegere E, Portzky G, van Heeringen K. The prevention and treatment of complicated grief: a meta-analysis. *Clin Psychol Rev* 2011; **31:** 69–78.

123 Aeschlimann A, Heim E, Killikelly C, et al. Cultural adaptation of a self-help app for grieving Syrian refugees in Switzerland. A feasibility and acceptability pilot-RCT. *Internet Interv* 2025; **39:** 100800.

124 Lichtenthal WG, Lief L, Rogers M, et al. EMPOWER: a multi-site pilot trial to reduce distress in surrogate decision-makers in the ICU. *J Pain Symptom Manage* 2024; **67:** 512–24.

125 Reitsma L, Boelen PA, de Keijser J, Lenferink LIM. Self-guided online treatment of disturbed grief, posttraumatic stress, and depression in adults bereaved during the COVID-19 pandemic: a randomized controlled trial. *Behav Res Ther* 2023; **163:** 104286.

126 Kissane DW, Zaider TI, Li Y, et al. Randomized controlled trial of family therapy in advanced cancer continued into bereavement. *J Clin Oncol* 2016; **34:** 1921–27.

127 Kentish-Barnes N, Chevret S, Valade S, et al. A three-step support strategy for relatives of patients dying in the intensive care unit: a cluster randomised trial. *Lancet* 2022; **399:** 656–64.

128 Zisook S, Shear MK, Reynolds CF, et al. Treatment of complicated grief in survivors of suicide loss: a HEAL report. *J Clin Psychiatry* 2018; **79:** 17m11592.

129 Hostetler CM, Ryabinin AE. Love and addiction: the devil is in the differences: a commentary on "the behavioral, anatomical and pharmacological parallels between social attachment, love and addiction". *Psychopharmacology* 2012; **224:** 27–29.

130 Stelzer EM, Zhou N, Merzhvynska M, et al. Clinical utility and global applicability of prolonged grief disorder in the ICD-11 from the perspective of Chinese and German-speaking health care professionals. *Psychopathology* 2020; **53:** 8–22.

131 Bryant RA, Ekasawin S, Chakrabhand S, Suwanmitri S, Duangchun O, Chantaluckwong T. A randomized controlled effectiveness trial of cognitive behavior therapy for post-traumatic stress disorder in terrorist-affected people in Thailand. *World Psychiatry* 2011; **10:** 205–09.

132 Bryant RA, Bawaneh A, Awwad M, et al. Effectiveness of a brief group behavioral intervention for common mental disorders in Syrian refugees in Jordan: a randomized controlled trial. *PLoS Med* 2022; **19:** e1003949.

133 Tay AK, Mohsin M, Foo CYS, Rees S, Silove D. Long-term efficacy of brief psychological treatments for common mental disorders in Myanmar refugees in Malaysia: 12-month follow-up of a randomized, active-controlled trial of integrative adapt therapy *v* cognitive behavioral therapy. *Psychol Med* 2023; **53:** 6055–67.

134 Wagner B, Rosenberg N, Hofmann L, Maass U. Web-based bereavement care: a systematic review and meta-analysis. *Front Psychiatry* 2020; **11:** 525.

135 Boelen PA, Lenferink LIM, Spuij M. CBT for prolonged grief in children and adolescents: a randomized clinical trial. *Am J Psychiatry* 2021; **178:** 294–304.

136 Dorsey S, Lucid L, Martin P, et al. Effectiveness of task-shifted trauma-focused cognitive behavioral therapy for children who experienced parental death and posttraumatic stress in Kenya and Tanzania: a randomized clinical trial. *JAMA Psychiatry* 2020; **77:** 464–73.

137 Sandler I, Tein JY, Wolchik S, Ayers TS. The effects of the family bereavement program to reduce suicide ideation and/or attempts of parentally bereaved children six and fifteen years later. *Suicide Life Threat Behav* 2016; **46** (Suppl 1)**:** S32–8.

138 Sandler IN, Ma Y, Tein JY, et al. Long-term effects of the family bereavement program on multiple indicators of grief in parentally bereaved children and adolescents. *J Consult Clin Psychol* 2010; **78:** 131–43.

139 Aeschlimann A, Heim E, Killikelly C, Arafa M, Maercker A. Culturally sensitive grief treatment and support: a scoping review. *SSM Ment Health* 2024; **5:** 5.

140 Gone JP. Re-imagining mental health services for American Indian communities: centering Indigenous perspectives. *Am J Community Psychol* 2022; **69:** 257–68.

141 WHO. Mental health. https://www.who.int/health-topics/mental-health#tab=tab_1 (accessed Jan 6, 2025).

142 Smith KV, Ehlers A. Cognitive predictors of grief trajectories in the first months of loss: a latent growth mixture model. *J Consult Clin Psychol* 2020; **88:** 93–105.