Prolonged Grief:

Etiology and Management

Christopher Magoon, MD; Sharmin Ghaznavi, MD, PhD; and Theodore A. Stern, MD

Lessons Learned at the Interface of Medicine and Psychiatry

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

Prim Care Companion CNS Disord 2025;27(1):24f03812

Author affiliations are listed at the end of this article.

Have you struggled to help people grieve after the loss of a loved one? Have you been uncertain about whether your patients are grieving, depressed, or experiencing posttraumatic stress disorder (PTSD)? Have you wondered whether they would benefit from talking therapy or a psychopharmacologic intervention? If you have, the following case vignette and discussion should prove useful.

CASE VIGNETTE

Ms A, a 21-year-old woman, was referred by a university health service for a psychiatric evaluation and for recommendations regarding an antidepressant medication. She had been reporting persistent low mood, difficulty with concentration, difficulty sleeping, anhedonia, and passive suicidal ideation (SI) following the death of her father 10 months earlier. Although her father had been chronically ill, a COVID-19 infection and respiratory failure led to his family's decision to stop life-prolonging interventions; he passed away surrounded by his family.

Her psychiatric history was notable for 1 depressive episode in high school that resulted in an impulsive, but near-lethal, overdose of acetaminophen, which was followed by a psychiatric hospitalization. After her hospital discharge, she was started on "a medication" (however, she did not recall its name) and received outpatient psychiatric services for several months until she stopped attending appointments, when she felt she was well enough to manage on her own. Since then, she had been functioning well and gained admission to an elite university and had not received any further mental health services. She had some difficulty adjusting to campus life as a freshman, but she was euthymic, social, and meeting her scholastic demands as a premed student until her father died during her sophomore year.

During her psychiatric assessment, Ms A was dysphoric, tearful, and ruminating about her father's death. She reported consistently low mood, difficulty with concentration, difficulty sleeping, passive SI, and anhedonia. She was diagnosed with major depressive disorder (MDD) and started on escitalopram; the dose was uptitrated to 20 mg/day with some improvement. Bupropion XL 150 mg/day was added, with further remission of her depressive symptoms. After 3 months on these medications, despite improvement in her depressive symptoms, she continued to ruminate about her father's death and experienced frequent waves of yearning for him. She remained socially isolated, as she resented her classmates whose parents were both still alive; in addition, she consistently avoided reminders of his death. Most notably, she avoided being near the hospital in which her father died, and she avoided any class readings or medical school admission test prep questions related to lungs or viruses, as they reminded her of her father's passing. She denied having thoughts of suicide, and cited protective factors (eg, her remaining family members), but noted that she "very much looked forward" to reuniting with her father in the afterlife.

DISCUSSION

What Is Grief, and Why Does It Hurt So Much?

Grief is the reaction to a meaningful loss. While grief can stem from different kinds of loss, it is perhaps most well understood in the context of losing someone

Clinical Points

- Symptoms of prolonged grief disorder (PGD) include yearning for and preoccupation about the deceased, as well as a loss of sense of self, suicidal ideation, and feeling isolated from others, with continued distress or impairment 1 year after the loss for adults (and 6 months for children and adolescents).
- The sadness in PGD is more loss specific, while depression is characterized by sadness and anhedonia.
- Posttraumatic stress disorder is predominantly triggered by danger and is characterized by fear and hyperarousal, while PGD is triggered by loss, yearnings, and longings.
- The "gold standard" treatment for PGD is a 16-session manualized therapy.
- Although no medications are indicated for PGD, psychiatric comorbidities should be managed aggressively.

important, particularly to death. Although everyone responds to such loss differently, there are common features, including feelings of yearning and longing, thinking about the deceased, and feeling detached from others. People who have recently lost a loved one often feel lost or adrift. However, because the loss is permanent, grief is also permanent—although it evolves over time. Shortly after the death, the intensity of the grief is often disruptive. Grief can be so painful, in part, because the deceased may have been a person with whom we felt safe and more authentic. With the loss of such "attachment figures," we can feel adrift, confused, or threatened. However, even when the relationship with the deceased was difficult, people can experience significant grief following the loss.

Fortunately, most people gradually adapt to the loss. While it is natural for a bereaved individual to feel pangs of sadness about the loss, over time, the overpowering acute grief typically transforms into a restoration of the capacity to lead a meaningful life with fulfilling relationships, memories of the deceased that are not as emotionally charged, and the full range of human emotions. The bereaved individual still carries the loss—but there is room for more emotions. When an individual gets "stuck" in the acute grief phase and is unable to integrate the painful loss into their lives, prolonged grief disorder (PGD) is diagnosed.[1]

Who Is at Risk for Prolonged Grief?

Despite PGD being a relatively new diagnosis, added to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*), in March 2022,[2] numerous studies have looked at the risk factors for PGD. Buur and colleagues[3] reviewed 120 studies, with over 61,000 participants, and found that pre-loss grief symptoms (also known as "anticipatory grief") and pre-loss depressive symptoms were most closely associated with the development of prolonged grief symptoms. They also found significant, although less robust, associations with unexpected death, violent or unnatural death, low education level, low income, female gender, an anxious attachment style, and death of a child or a partner.[3] In other words, those who practice in primary care settings should be aware that individuals who have higher levels of depression and/or difficulty adapting to the loved one's illness or disability (ie, pre-loss grief) may benefit from a referral for specialized mental health services. In addition, while the *DSM* cutoff for PGD diagnosis is 12 months, evidence shows that those who have particularly intense grief symptoms earlier in their course may also benefit from referral to a specialist.[4,5]

How Does PGD Differ From Typical Grief, MDD, and PTSD?

To meet *DSM-5-TR* diagnostic criteria for PGD, the loss must have occurred more than 1 year prior for adults, or 6 months prior for children and adolescents. PGD and more typical grief have similar symptoms (ie, yearnings, longings, preoccupations, disbelief, avoidance, and identity confusion), but PGD and typical grief differ in terms of the persistence and intensity of symptoms, as well as the degree to which they disrupt a person's life. In typical grief, the bereaved individual can feel intense pangs (of yearning, longing, and preoccupation with the death), but these are less persistent and pervasive than those found in PGD. Similarly, in an individual with more typical grief, the symptoms of disbelief and avoidance play a smaller and more intermittent role in coping with the loss, while an individual with PGD experiences these symptoms persistently and pervasively.

While PGD has features that overlap with MDD, these conditions are different. At its core, PGD is characterized by a yearning and longing for the deceased, while depression is characterized by sadness and anhedonia. Those with PGD tend to experience painful waves of emotion related to the deceased, while an individual with MDD experiences enduring depressed mood. SI is common in both conditions; however, individuals with PGD often have SI that is fueled by not wanting to be alive without the deceased (or by wanting to join them in the afterlife), while SI in individuals with MDD is fueled by hopelessness and low self-worth. Notably, while depression and PGD are distinct, PGD and MDD are often comorbid conditions.

When a death has been violent or accidental, PTSD and PGD commonly co-occur, yet there are fundamental distinctions. PTSD is predominantly triggered by danger, and it is characterized by fear and hyperarousal, while PGD is triggered by loss, yearnings, and longings. Thoughts associated with PTSD are related to the traumatic experience itself and are often frightening; in PGD, emotionally painful thoughts focus on the deceased's absence; however, they are rarely frightening.

Despite these differences, comorbidity of PGD and PTSD is commonplace.[1]

Why Does Prolonged Grief Develop?

PGD is thought to result from the derailment of the natural grief process. Typically, a bereaved individual adapts to the reality of death, painful as that reality might be. Over time, the finality of the death and its consequences are accepted. In PGD, this process is sidetracked, and the bereaved individual gets stuck and becomes preoccupied with the loss for years—or even decades—as if the death had occurred very recently.

Did Deaths During the COVID-19 Pandemic Predispose People to More Severe and Prolonged Grief Than Deaths From Other Causes?

In the early phases of the COVID-19 pandemic, many experts predicted that there would be more intense and prevalent grief symptoms among the bereaved due to the traumatic nature of COVID-related deaths, disrupted rituals of mourning due to distancing requirements, and heightened stress throughout the population.[6,7] Subsequent research supported these predictions, as researchers found that those who lost loved ones in the early phases of the pandemic (August 2020 to January 2021) had more intense PGD symptoms compared to nonpandemic bereaved populations. The data indicated numerous pandemic-related factors (including social isolation, unexpected deaths, less favorable care experiences at the end of life, including visitor restrictions, and disproportionately high death rate among those with low socioeconomic status) that might have facilitated this symptomatic increase.[6,7]

How Can I Screen Patients for Prolonged Grief?

Patients should be asked about the significant losses in their life, and if such losses occurred, they should be asked about how they managed their grief. If this conversation raises concerns about the possibility of PGD, well-validated screening instruments for PGD are available. The most extensively studied screening tool is the Brief Grief Questionnaire, a 5-item tool for which there are free online versions.[8] This screening instrument has been broadly rated as acceptable and feasible, even in primary care settings.[9]

What Does the Evaluation for Prolonged Grief Involve?

The evaluation for PGD attempts to assess levels of distress and impairment from grief-related symptoms, as well as potential comorbidities (including depression, PTSD, and substance use disorders). In addition, since many individuals with PGD have thoughts of suicide, clinicians should pay attention to the patient's safety. In addition to the assessment of grief symptoms during the diagnostic interview, clinicians can use the Inventory of Complicated Grief, a 19-item survey of grief-related symptoms for which higher scores are associated with greater impairment.[10]

How Can Prolonged Grief Be Managed?

Most bereaved individuals can manage their grief without a specialized intervention. However, for those who develop PGD, effective, evidence-based psychotherapeutic treatments are available. PGD therapy (PGDT) is a manualized, 16-session therapy that focuses on facilitating the natural adaptation to loss. Two large randomized controlled trials found that PGDT was superior to non–grief-specific forms of therapy.[11,12] While PGDT is the best validated treatment, other cognitive-behavioral therapy grief-specific treatments have demonstrated efficacy, and several others (including an online version) are in development. The Columbia Center for Prolonged Grief has a database of therapists who offer PGDT and training opportunities and resources for those looking to learn the treatment.[1]

Currently, there are no US Food and Drug Administration–approved medications for PGD, and there are limited data that suggest little to no efficacy of medications for the treatment of grief symptoms. In individuals who are undergoing PGDT, exposure-based exercises may benefit from limiting the use of benzodiazepines or other anxiety-reducing medications, since it is important to ensure they are not being used as a means of avoiding emotions that the therapy seeks to address. However, this decision should be made on an individual level and with collaboration between the patient and their therapist.

Managing Psychiatric Comorbidities

In individuals with PGD and MDD, it is reasonable for primary care providers to offer an antidepressant medication. However, it is important that this is done with the knowledge that antidepressants are effective for the treatment of depressive symptoms found in bereaved individuals, but not for grief-related symptoms. That said, treating depressive symptoms with an antidepressant may allow patients to engage more effectively in PGDT.[1,13] While antidepressant efficacy is less well studied in individuals with comorbid PTSD and PGD, it is also reasonable to adhere to standard PTSD medication regimens, which typically include use of a serotonin reuptake inhibitor plus prazosin if a sleep disturbance is present.

What Happened to Ms A?

Given Ms A's prolonged and intense grief symptoms, she was referred for PGDT. During the intake interview, the therapist confirmed the remittance of her earlier depressive symptoms and the presence of PGD. Ms A

engaged fully in PGDT, and by the midpoint in treatment, she tolerated recounting of her father's death and exhibited less avoidance of reminders of his death. She gained confidence and felt better. By the end of treatment, she reflected on the fact that, while she still sometimes missed her father quite intensely and was pained by his absence, she knew that he would always be with her, and she was grateful for the time she had with him.

CONCLUSIONS

Although PGD following a loss is a condition recently added to the *DSM-5-TR*, given that it is relatively common and highly treatable, it should be familiar to all clinicians. PGD has several features that overlap with MDD and PTSD (when the death was accompanied by trauma) but is a distinct entity for which a well-validated, targeted treatment is available (ie, PGDT). Although medications have not been shown to target grief, this should not stop clinicians from using pharmacotherapy to target psychiatric comorbidities in bereaved individuals.

Article Information

Published Online: February 4, 2025. https://doi.org/10.4088/PCC.24f03812

Submitted: July 10, 2024; accepted October 7, 2024.

To Cite: Magoon C, Ghaznavi S, Stern TA. Prolonged grief: etiology and management. *Prim Care Companion CNS Disord*. 2025;27(1):24f03812.

Author Affiliations: Department of Psychiatry, Massachusetts General Hospital, Boston, Massachusetts (all authors); Harvard Medical School, Boston, Massachusetts (all authors).

Corresponding Author: Christopher Magoon, MD, Department of Psychiatry, Massachusetts General Hospital; Harvard Medical School, 1 Bowdoin Sq, 6th Floor Boston, MA 02114 (cmagoon1@mgh.harvard.edu).

Drs Magoon and Ghaznavi are co-first authors.

Relevant Financial Relationships: None.

Funding/Support: None.

References

1. Szuhany KL, Malgaroli M, Miron CD, et al. Prolonged grief disorder: course, diagnosis, assessment, and treatment. *Focus (Am Psychiatr Publ)*. 2021;19(2):161–172.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Association Publishing; 2022.
3. Buur C, Zachariae R, Komischke-Konnerup KB, et al. Risk factors for prolonged grief symptoms: a systematic review and meta-analysis. *Clin Psychol Rev*. 2024;107:102375.
4. Djelantik AAAMJ, Smid GE, Kleber RJ, et al. Early indicators of problematic grief trajectories following bereavement. *Eur J Psychotraumatol*. 2017;8(suppl 6):1423825.
5. Nielsen MK, Carlsen AH, Neergaard MA, et al. Looking beyond the mean in grief trajectories: a prospective, population-based cohort study. *Soc Sci Med*. 2019;232:460–469.
6. 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.
7. 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(1):19.
8. Ito M, Nakajima S, Fujisawa D, et al. Brief measure for screening complicated grief: reliability and discriminant validity. *PLoS One*. 2012;7(2):e31209.
9. Patel SR, Cole A, Little V, et al. Acceptability, feasibility and outcome of a screening programme for complicated grief in integrated primary and behavioural health care clinics. *Fam Pract*. 2019;36(2):125–131.
10. Prigerson HG, Maciejewski PK, Reynolds CF, et al. Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Res*. 1995;59(1–2):65–79.
11. Shear K, Frank E, Houck PR, et al. Treatment of complicated grief: a randomized controlled trial. *JAMA*. 2005;293(21):2601–2608.
12. Shear MK, Wang Y, Skritskaya N, et al. Treatment of complicated grief in elderly persons: a randomized clinical trial. *JAMA Psychiatry*. 2014;71(11):1287–1295.
13. Bui E, Nadal-Vicens M, Simon NM. Pharmacological approaches to the treatment of complicated grief: rationale and a brief review of the literature. *Dialogues Clin Neurosci*. 2012;14(2):149–157.