

Prolonged Grief Disorder: A Narrative Review

Tiffany Field

University of Miami/Miller School of Medicine and Fielding Graduate University, USA

Corresponding author

Tiffany Field, PhD, University of Miami/Miller School of Medicine and Fielding Graduate University, USA.

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ABSTRACT

The prevalence of Prolonged Grief Disorder has ranged from 7% to 65% in different samples depending on the severity of the grief experience. A narrative review of the current literature (2024-2025) on Prolonged Grief Disorder has yielded papers on negative effects, risk factors, potential underlying biological mechanisms and interventions. The negative effects include loneliness, poor quality of life, depression, PTSD, psychosis and broken heart syndrome. The risk factors have included anxious attachment, rumination, anxiety, PTSD, insomnia, COVID, earthquake, terror, and relationship to the deceased. The potential underlying biological mechanisms have included oxytocin dysfunction and involvement of the nucleus accumbens (the reward region of the brain). Cognitive behavioral therapy has been the most frequently researched intervention.

Grief has been defined as the emotional response to loss. Bereavement is thought to be a period of grief and mourning over the loss. Seven stages of grief have been described as shock, denial, anger, bargaining, depression, testing, and acceptance. Prolonged Grief Disorder (also called Complicated Grief Disorder) has been defined as unresolved grief, persistent distress and impaired social skills.

This review is focused on brief summaries of 26 papers on Prolonged Grief Disorder published during 2024-2025. They are focused on effects, as well as predictors/risk factors for prolonged grief disorder, potential underlying biological mechanisms and interventions for negative effects. The empirical studies and review papers were derived from a search on PubMed and PsycINFO entering the terms grief and the years 2024-2025. Exclusion criteria for this review included proposed protocols, case studies and non-English language papers.

The publications can be categorized as prevalence of Prolonged Grief Disorder, negative effects of Prolonged Grief Disorder, predictors/risk factors, potential underlying biological mechanisms and interventions. Accordingly, this review is divided into sections that correspond to those categories. Although some papers can be grouped in more than one category, 4 papers are

focused on prevalence, 7 papers are focused on negative effects of Prolonged Grief Disorder, 10 papers on predictors/risk factors, 2 papers on potential underlying biological mechanisms and 6 papers on interventions. A discussion on methodological limitations of this literature follows those sections.

Prevalence of Prolonged Grief Disorder

The prevalence of Prolonged Grief Disorder has ranged from 7% to 65% depending on the severity of the grief experience (see table 1). In one study, Prolonged Grief Disorder (PGD) was described as intense yearning/longing for and preoccupation with thoughts and memories of the deceased person [1]. Seven per cent to 10% were noted to experience PGD. In another study, complicated grief was described as persistent distress and impaired social skills and was noted to happen in 10 to 20% of the sample [2].

Table 1: Prevalence of prolonged grief disorder (and first authors)

Prevalence	First Authors
7-10%-deceased person	Singer
10-20%-complicated grief	Bettemanne
34%-ISIS conflict	Jann
65%-earthquake	Ulusoy

Greater prevalence has been noted following terror and natural disasters. For example, in a study on internally displaced persons who fled their town in Iraq due to ISIS conflict and loss within the past five years, complicated grief symptoms were noted in more than half the sample [3]. Complicated Grief Disorder was diagnosed for 34% of the sample, PTSD for 12% and comorbid Complicated Grief Disorder and PTSD for 37%.

An even greater prevalence (65%) was noted for complicated grief four months after the TURKIYE earthquake in 2023 [4]. PTSD was noted in 21%, and depression in 16% of the survivors (N =529). The survivors reported loss of a loved one, fear of future earthquakes and a perceived decrease in control over life.

Negative Effects of Prolonged Grief

Several negative effects have been reported for prolonged grief disorder (see table 2). They include loneliness, reduced quality of life, depression, PTSD, psychosis, and cardiomyopathy (heart attack-like symptoms but no permanent damage).

Table 2: Negative effects of prolonged grief (and first authors)

Negative Effects	First Authors
Social and emotional loneliness and depression	Eisma
Lower quality of life	Eisma
Depression, anxiety and PTSD	Janshen
Psychosis	DelPozo-Herce
Cardiomyopathy	Mughal

In a longitudinal study, prolonged grief symptoms predicted social and emotional loneliness, as well as depression symptoms [5]. Cross-lagged panel analysis revealed that prolonged grief led to severe general, **social and emotional loneliness and depression** symptoms. The reverse of those symptoms leading to grief was not noted.

In a study entitled “ICD - 11 and DSM - five - TR prolonged grief symptoms and quality of life”, diagnoses on both systems concurrently predicted **lower quality of life**, but only the ICD - 11 predicted lower quality of life six months later [5].

In a paper entitled, “The grief debate, the DSM and practice”, the question was raised as to whether complicated grief is really depression [6]. Normal bereavement or grief was being diagnosed as major depression. The challenges were distinguishing grief from depression and both from normal grief.

Grief has normally been comorbid with symptoms of depression, anxiety, and PTSD. In a systematic review, bidirectional associations were noted between prolonged grief symptoms and **depression, anxiety, and PTSD** (N=2914) [7]. Prolonged grief led to depression and PTSD but not the reverse. The authors referred to it as a transdiagnostic risk factor for depression and PTSD. They qualified their results, however, by discussing the extreme heterogeneity on the sample characteristics, the study designs, the stats and the measures.

Psychosis is also a negative effect of grief based on a review of 50 studies [8]. Greater risk occurred at less than 18 years

in a first-degree relative, and as a consequence of suicide or accidental death. Risk factors were comorbidity with mental problems, unemployment, economic difficulties and close ties with the deceased.

Cardiomyopathy (also called Takotsubo or broken heart syndrome) is another negative effect of grief [8]. This weakening of the left ventricle leads to apical ballooning (that resembles the takotsubo container for catching octopus in Japan). This weakening of the left ventricle results in heart-attack like symptoms, but it does not cause permanent damage. It occurs in women 90% of the time, mostly menopausal women and often resolves within one month.

Predictors/Risk Factors for Grief

Several risk factors have been the focus of papers on prolonged grief disorder (see table 3). They include race, anxious attachment, rumination, anxiety, PTSD, insomnia, COVID-19, earthquakes, and the relationship to the deceased.

Table 3: Predictors/Risk factors for prolonged grief disorder (and first authors)

Predictors/Risk Factors	First Authors
Race	Jamison-Petr
Attachment anxiety	Russ
Rumination and PTSD	Thimm
Insomnia	de lang
COVID	Alkasir
Earthquake	Ulusoy
Relationship to deceased, mental health and religious beliefs	Jann
Unnatural death, female gender, death of a child or partner	Buur

Race has been a noted risk factor for Prolonged Grief Disorder. In a paper entitled "Understanding black and African-American grief", Prolonged Grief Disorder was noted to be more prevalent and occurred at an earlier age for black Americans than for white Americans [9].

In a systematic review of 22 studies (N= 5149) on the relationship between adult attachment and complicated grief, **attachment anxiety** was associated with complicated grief [10]. In this review, avoidant attachment was less associated with complicated grief. These cross-sectional studies were based on the adult attachment questionnaire.

Grief-related **rumination** as well as **PTSD** have also been risk factors for prolonged grief in a longitudinal study of bereaved adults after the 2011 terror attack in Norway (N= 110) [11]. In this study, the Rumination Scale, the Inventory of Complicated Grief and the Impact of Event Scale were administered at 12 and 74 months after the loss. Rumination led to prolonged grief after the 12 month assessment but not after the 74 month assessment and post-traumatic stress symptoms of avoidance occurred after the 12 and 74 month assessments and hyperarousal occurred after the 74 month assessment. Just as anxiety and PTSD have resulted from grief, both anxiety and PTSD are also said to be risk factors for prolonged grief disorder (N=259) [9].

In a sample of recently bereaved (N=220 adults who were bereaved for less than six months), 60% of those with a chronic trajectory of **insomnia** met the criteria for prolonged grief disorder [12]. The authors suggested that insomnia and bereavement had a bidirectional relationship.

Natural disasters including COVID and the Turkiye earthquake have been notable risk factors for grief in this current literature. In the COVID study entitled "Bereavement during or not during the pandemic", complicated grief during **COVID** was intensified (N= 580 who lost a loved one) [13]. The severity, surprisingly, was not reduced by social support.

In the study already mentioned on survivors of the Turkiye **Earthquake** (N=529), 65% experienced complicated grief [4]. The authors suggested that the survivors were experiencing loss of a loved one, fear of future earthquakes and a decrease in their perceived life control.

In a systematic review of 46 studies on traumatic loss, significant predictors of pathological grief were **relationships to the deceased, mental health issues and religious beliefs** [3]. As the authors suggested, there is a great need for longitudinal studies that begin early after the loss, that include up-to-date measures and that assess comorbidities.

Multiple predictors/risk factors were noted in a systematic review and meta-analysis of 120 studies (N= 61,580) [14]. Nine risk factors were significant including **pre-loss grief symptoms and depression, unexpected death, violent/unnatural death, low education, low income, female gender, anxious attachment, and death of a child or partner.**

Potential Underlying Biological Mechanisms for Prolonged Grief Disorder

fMRI studies have been conducted to explore potential underlying biological mechanisms for prolonged grief disorder (see table 4). In one sample, the grief elicitation task and the emotional counting Stroop task were used [1]. The data revealed **activation of reward pathways**, including the **nucleus accumbens** as grief severity increased.

Table 4: Potential underlying biological mechanisms for prolonged grief disorder (and first authors)

Mechanisms	First Authors
Activation of reward pathways (nucleus accumbens)	Singer
Dysfunctional cerebral oxytocinergic signaling	Bettemanne

In another sample, persistent hyperactivation of the nucleus accumbens as well as **dysfunctional cerebral oxytocinergic signaling** were noted [2]. This was accompanied by limiting the decrease of interpersonal attachment to the deceased during the acute phase and the searching for interpersonal relationships during the recovery phase.

Interventions for Prolonged Grief Disorder

Several different therapies have been studied for their effects on prolonged grief disorder (see table 5). Although cognitive

behavior therapy has been the most frequently studied, other therapies have included acceptance and commitment therapy, and EMDR.

Table 5: Interventions for prolonged grief disorder (and first authors)

Interventions	First Authors
Cognitive behavioral therapy	Bryant, Rosner, Komischke-Konnerup, Hao
Acceptance and commitment therapy	Alkasir
Eye movement desensitization and re-processing	Spicer

In a randomized clinical controlled trial, **cognitive behavioral therapy (CBT)** was compared with mindfulness for the treatment of prolonged grief disorder [15]. In this study (N=100), 90-minute weekly sessions were given for 11 weeks. Grief - focused cognitive behavioral therapy included live sessions of recalling memories of the deceased, cognitive restructuring and planning future social and positive activities. The mindfulness exercises were adapted to tolerate grief - related distress. The Prolonged Grief - 13 Scale (PG-13) was administered at baseline, one week and six months post the end of treatment. At the six-month assessment, CBT was more effective in reducing scores on the PG - 13 scale as well as decreasing depression based on the BDI (Beck Depression Inventory) and grief - related cognition.

In another randomized, clinical trial, grief - specific CBT was compared to present - centered therapy (PCT) [16]. In this trial that took place in Germany on adults 18 to 75-years-old, the Prolonged Grief Disorder - 13 Scale was used. The participants were recruited from university outpatient clinics. PG/CBT focused on the worst moment of loss and cognitive restructuring of grief - related cognition, solutions - focus and experiential methods (e.g. a walk to the grave exercise). The PCT group received supportive relations and coping with daily problems. CBT was more effective at reducing the severity of Prolonged Grief Disorder and depression at the 12 month follow up assessment (N=212).

In a systematic review and meta-analysis of 22 studies on grief - focused CBT for prolonged grief (N=2602 adults), CBT had a medium effect on prolonged grief disorder symptoms at the end of the intervention and a large effect at the follow-up assessment [17]. Small to medium effects were noted on PTSD, depression and anxiety post intervention. The grief - focused CBT was apparently not as relevant for PTSD, depression and anxiety. As the authors noted, the inconsistency and indirectness of meta-analytic evidence was a methodological problem in their research.

In a systematic review and network meta-analysis of psychotherapies for prolonged grief disorder, seven data bases including 55 studies assessing 11 different psychological interventions were included [18]. Behavior therapy, CBT, family therapy, psychodynamic therapy and cognitive therapy reduced grief symptoms. However, only CBT reduced grief, depression, PTSD and anxiety.

Acceptance and commitment therapy has also been effective in reducing symptoms of grief for survivors of individuals who died from COVID (N=38) [13]. In addition, in this study, acceptance and commitment therapy also increased quality of life.

Eye movement desensitization and re-processing (EMDR) has been effective for reducing prolonged grief symptoms [19]. In this research, EMDR focused on processing memories, blocking current triggers and future fears, and living life beyond the loss.

Methodological Limitations of this Literature on Prolonged Grief Disorder

Several methodological limitations can be noted for this literature including heterogeneity of sample characteristics, study designs, variables, and types of statistical analyses. These variations across studies make it difficult to conduct meta-analyses and make general conclusions about negative effects, risk factors, potential underlying biological mechanisms and interventions for prolonged grief disorder.

The samples have been primarily older adults. This was surprising given that the average age widow is 59 years and more than half of women in the U.S. are reputedly widowed before the age of 65 [11]. In addition, the same authors reported that 4% of children less than 15 have experienced the loss of a parent. These data highlight the need for studying broader age range samples or at least some researchers focusing on younger adults and children.

The design of most of the studies has been cross-sectional rather than longitudinal. Directionality or causality cannot be determined in cross-sectional studies, making it difficult to know temporally whether the effects and risk variables may in fact be reciprocal or comorbid. For example, PTSD has been reported by some researchers as a negative effect and by others as a risk factor.

Surprisingly, researchers in this recent literature have not explored differences across the different stages of grief. The stage of shock would likely be different from the stage of anger. And, if the researchers are assessing grief at the depression stage, they would likely find depression as a negative effect. Similarly, the acceptance stage would likely have fewer negative effects than the earlier stages of shock, denial, and anger.

Most studies were focused on a single variable rather than multiple variables. In the few multivariate studies, multiple variables were associated with prolonged grief. Surprisingly, only one study was focused on physical effects. The cardiomyopathy (takotsubo) effect in that study suggests that other less serious medical conditions and physical health in general would be affected by prolonged grief.

Also surprisingly, only one study addressed the relationship to the deceased person as a risk factor. It's likely that the loss of a child or significant other would have more serious effects than the loss of a distant relative or friend.

Only two potential underlying biological mechanisms were explored, including a dysfunctional oxytocin system and the related involvement of the nucleus accumbens reward pathways.

These findings suggest serious negative effects of prolonged grief on the brain.

Despite these methodological limitations, the current literature on the negative effects of prolonged grief, the risk factors, the potential underlying biological mechanisms and the intervention effects has been informative. The positive effects noted for cognitive behavioral therapy are consistent with those noted for other significant mental health problems including depression and PTSD. Although seven stages of grief are considered normal bereavement, prolonged grief or complicated grief at any of these stages would suggest the need for intervention such as cognitive behavioral therapy.

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