TRAUMA- AND STRESSOR-RELATED DISORDERS

Prolonged Grief Disorder

PGD

DSM-5-TR 309.89 | ICD-10-CM F43.81

Intense yearning or preoccupation with a deceased loved one persisting past 12 months, with identity disruption and functional impairment.

PREVALENCE	TIME THRESHOLD	HIGHEST RISK	COURSE
~4% of bereaved adults	12 mo adults / 6 mo children	Violent or sudden loss	Chronic without treatment

CLINICAL PICTURE

- Persistent intense yearning for the deceased or preoccupation with thoughts and memories that dominates the day nearly every day for months.
- Identity disruption is central: patients describe part of themselves as having died and cannot say who they are apart from the lost person.
- Marked disbelief about the death, avoidance of reminders, and intense emotional pain including anger, bitterness, and guilt persist unabated.
- Emotional numbness, a sense that life is meaningless, and profound loneliness coexist with difficulty reengaging in work or relationships.
- Proximity-seeking is common: keeping the room untouched, wearing the person's clothing, sleeping with possessions, or daily cemetery visits.
- Unlike depression, distress is loss-focused and cue-triggered, and pleasure in unrelated activities can persist between acute pangs of grief.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires the death of a person close to the bereaved at least 12 months earlier for adults, or at least 6 months earlier for children and adolescents.
- The core symptom is intense yearning for the deceased or preoccupation with thoughts or memories, present most days to a clinically significant degree in the past month.
- At least three of eight accessory symptoms in the past month, including identity disruption, marked disbelief, avoidance of reminders, and intense emotional pain.
- The remaining accessory symptoms are difficulty reintegrating into relationships and activities, emotional numbness, a sense of meaninglessness, and intense loneliness.
- The reaction must clearly exceed cultural, religious, and social norms for the person's context and not be better explained by another mental disorder.

NEUROBIOLOGY & PHYSIOLOGY

- Reminder cues activate nucleus accumbens reward circuitry in prolonged grief but not in adaptive grief, supporting a craving-like mechanism.
- Yearning intensity tracks with dopaminergic reward signaling, reframing the disorder as attachment-related craving rather than simple sadness.
- Elevated inflammatory markers, a flattened cortisol rhythm, and fragmented sleep accompany persistent grief and mediate its physical health risk.
- Bereavement sharply raises short-term cardiovascular risk, with takotsubo cardiomyopathy and myocardial infarction clustering in the first weeks.
- Neurocognitive testing shows attentional bias toward loss-related stimuli and reduced specificity of autobiographical memory retrieval.
- Oxytocinergic attachment systems that normally maintain the bond become maladaptive when the attachment figure is permanently unavailable.

PSYCHOLOGICAL MECHANISMS

- Attachment theory frames the disorder as failure to revise the internal working model that still codes the deceased as findable and retrievable.
- The dual process model describes healthy oscillation between loss-oriented and restoration-oriented coping; prolonged grief stalls on the loss side.
- Avoidance of reminders and rumination about the circumstances of the death both block the corrective learning that grief resolution requires.
- Maladaptive appraisals about the death, self-blame, and the belief that grieving less would betray the deceased actively maintain symptoms.
- Risk factors include violent or unexpected death, loss of a child or partner, insecure attachment, low social support, and prior caregiver strain.

DIFFERENTIAL & COMORBIDITY

- Normal grief also involves yearning and pangs, but intensity and preoccupation decline over months while identity and role functioning recover.
- Major depression shows pervasive low mood and anhedonia across all domains, whereas prolonged grief remains loss-focused with pleasure elsewhere.
- PTSD after a traumatic death centers on fear and intrusive trauma imagery, while prolonged grief centers on separation distress and yearning.
- Comorbidity is high, with major depression, PTSD, and alcohol use disorder each present in a substantial minority of diagnosed cases.
- Suicidal ideation, including an explicit wish to join the deceased, is markedly elevated and must be assessed directly at every contact.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is FDA-approved for prolonged grief disorder, and targeted psychotherapy is first-line and outperforms antidepressants alone.
- **Citalopram** added to complicated grief therapy did not improve grief outcomes beyond therapy alone, though it did help depressive symptoms.
- Treat comorbid major depression or PTSD on their own merits using **SSRIs** or **SNRIs** at standard doses for standard durations.
- **Naltrexone** has been studied for the reward-craving mechanism, but the evidence remains preliminary and it is not standard care.
- Avoid **benzodiazepines**, which do not alter the grief trajectory and impede the emotional processing that effective treatment requires.

PSYCHOTHERAPY

- **Complicated grief treatment** over 16 sessions outperformed interpersonal psychotherapy in randomized trials, with roughly double the response rate.
- The protocol combines imaginal revisiting of the death, situational exposure to avoided reminders, and structured work on restoration goals.
- **Prolonged grief disorder therapy** is the manualized descendant of that protocol and is the version now used in clinical training programs.
- Grief-focused **CBT** that includes imaginal exposure to the death outperformed the same therapy without exposure in a randomized trial.
- Internet-delivered grief-focused **CBT** shows moderate to large effects and extends access where trained grief clinicians are scarce.

ADJUNCT & SUPPORTIVE

- Measure severity with the **PG-13-Revised**, which is aligned to DSM-5-TR criteria, or the Inventory of Complicated Grief for tracking over time.
- Do not offer universal grief counseling to every bereaved person; routine debriefing shows no benefit and may harm low-risk mourners.
- Peer support groups and bereavement services help many, but screen for the minority who need formal treatment rather than support alone.
- Address sleep directly with **CBT-I**, since insomnia is near-universal in prolonged grief and predicts poorer response to grief treatment.
- Build in memorializing rituals, anniversary planning, and concrete re-engagement goals, since restoration work is as essential as loss processing.

CLINICAL PEARLS

- 12 months in adults, 6 months in children: the threshold is a floor, not a target.
- Yearning that feels like craving, not sadness that colors everything, is grief.
- Complicated grief therapy beats medication; added citalopram did not help grief.

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NOTE

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