Review Article ISSN 2639-8451

Addiction Research

Prolonged Grief Disorder: Treatment Approaches and the Spiritual Dimensions of Healing

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Received: 18 Mar 2025; **Accepted:** 25 Apr 2025; **Published:** 07 May 2025

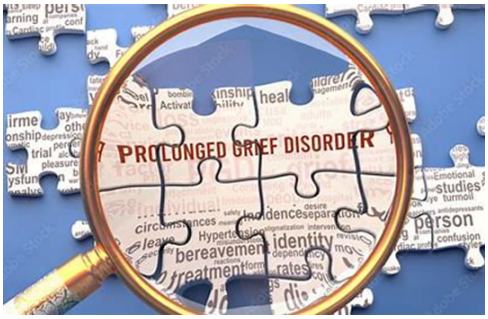
Citation: Julian Ungar-Sargon. Prolonged Grief Disorder: Treatment Approaches and the Spiritual Dimensions of Healing. Addict Res. 2025; 9(1): 1-7.

ABSTRACT

Prolonged grief disorder (PGD) is a recently recognized mental health condition characterized by persistent, intense grief that continues beyond culturally appropriate norms and causes significant functional impairment. This review examines the current diagnostic conceptualization of PGD, including its inclusion in both the ICD-11 and DSM-5-TR, and explores the evidence supporting its distinction as a separate diagnostic entity. We synthesize research on prevalence, risk factors, and treatment approaches, with special emphasis on evidence-based psychological interventions. Furthermore, this article incorporates perspectives on the spiritual dimensions of grief and healing, drawing from the interdisciplinary work of Ungar-Sargon on holistic approaches to recovery and healing. Clinical implications and future research directions are discussed, highlighting the need for greater awareness among healthcare providers and continued development of targeted therapeutic approaches.

Keywords

Prolonged grief disorder, Complicated grief, Bereavement, Psychotherapy, Neurobiology, Reward system, Oxytocin, Neuroimaging, fMRI, Nucleus accumbens, Cognitive behavioral therapy, Spirituality, Holistic healing, Structural brain changes, Attachment.



Introduction

Grief is a universal human experience following the death of a loved one. While most individuals navigate through acute grief that gradually lessens over time, a significant minority develop a persistent, intense form of grief that impairs daily functioning [1]. This condition, now formally recognized as prolonged grief disorder (PGD), has recently been incorporated into major diagnostic classification systems the International Classification of Diseases, 11th edition (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision (DSM-5-TR) [2,3].

The formal recognition of PGD represents the culmination of decades of research demonstrating that pathological grief responses constitute a distinct clinical syndrome requiring specific treatment approaches [4]. However, this development has not been without controversy, with ongoing debates about the potential medicalization of normal grief reactions [5]. Such tensions reflect broader philosophical questions about the boundaries between normal human suffering and psychopathology.

As I have previously noted: "The transition between illness and health has historically been recognized as critical in re-entering home and work spaces" [6]. This perspective resonates particularly well when considering PGD, where the natural process of grief becomes prolonged, complicated, and interferes with reintegration into daily life.

This review aims to provide a comprehensive examination of current knowledge on prolonged grief disorder, integrating empirical research with perspectives on holistic recovery approaches that acknowledge the spiritual dimensions of grief and healing.

The concept of pathological grief has evolved considerably over time. Early proposals included terms such as "complicated grief disorder", "traumatic grief" [8], and "persistent complex bereavement disorder" (DSM-5, 2013) [7]. These various conceptualizations reflected efforts to distinguish normal grief from pathological responses requiring clinical intervention.

The inclusion of PGD in both ICD-11 and DSM-5-TR represents a significant milestone in the field's understanding of grief-related psychopathology. However, it is important to note that while both classification systems use the same term, there are notable differences in their diagnostic approaches and criteria [9].

Diagnostic Criteria

According to the ICD-11, PGD is characterized by a persistent and pervasive grief response beyond expected social, cultural, or religious norms, typically lasting at least six months following the death [10]. Core symptoms include intense yearning for the deceased or persistent preoccupation with them, accompanied by intense emotional pain (e.g., sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of oneself, inability to experience positive mood, emotional numbness, and difficulty engaging with social or other activities) [3].

The DSM-5-TR criteria for PGD require that the death occurred at least 12 months prior to diagnosis (for adults) and include the presence of at least three of the following symptoms: identity disruption, marked sense of disbelief about the death, avoidance of reminders that the person is dead, intense emotional pain, difficulty moving on with life, emotional numbness, feeling that life is meaningless, and intense loneliness [11].

These differences highlight ongoing debates about the optimal diagnostic threshold for PGD, with concerns about potentially medicalizing normal grief if criteria are too broad [12].

Epidemiology

Research indicates that approximately 10% of bereaved individuals will develop prolonged grief disorder [13]. However, prevalence rates vary considerably depending on the diagnostic criteria used, the population studied, and the circumstances of the death. Recent studies using the current diagnostic criteria found that the point prevalence of PGD among bereaved individuals ranges from 4.7% to 6.8% [14].

Risk Factors

Several factors have been identified that increase the risk of developing PGD:

Relationship to the deceased: Spouses, parents, and children of the deceased tend to display higher severities of symptoms [15].

Circumstances of death: The risk is greater when the death is sudden, violent, or traumatic [16].

Personal characteristics: Older adults and individuals with a history of depression or bipolar disorder are at increased risk [17].

Social factors: Limited social support and concurrent stressors can exacerbate grief responses [18].

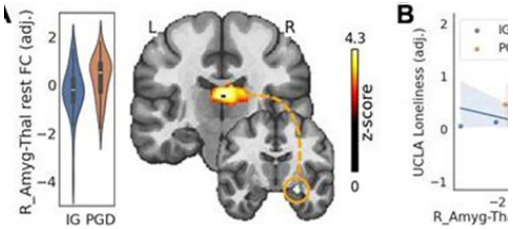
Understanding these risk factors is crucial for early identification and intervention with individuals who may be vulnerable to developing PGD.

Clinical Presentation

The hallmark features of PGD include persistent yearning or longing for the deceased, intense preoccupation with thoughts or memories of the deceased, and difficulty accepting the reality of the loss [8]. These symptoms are often accompanied by emotional pain, including sadness, guilt, anger, or numbness, that does not diminish significantly over time [19].

PGD is associated with significant functional impairment across multiple domains of life, including social relationships, occupational functioning, and physical health [20]. Research has demonstrated links between PGD and various negative health outcomes, including high blood pressure, increased rates of suicidality, and impaired immune function [21].

Furthermore, PGD frequently co-occurs with other mental health conditions, particularly depression, post-traumatic stress disorder (PTSD), and anxiety disorders [22]. Sleep disturbances are especially common, affecting an estimated 80% of individuals with PGD [23]



Neurobiological Findings

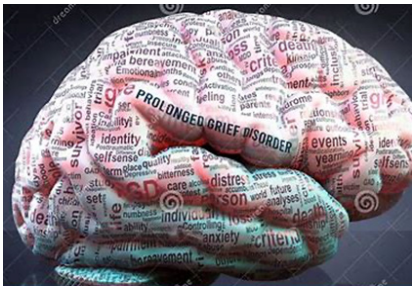
A growing body of neuroimaging research has illuminated the unique neurobiological mechanisms underlying prolonged grief disorder, particularly focusing on the neural reward system. Unlike other mental health conditions, PGD has a distinctive neurobiological signature involving brain circuits associated with attachment, reward processing, and emotional regulation.

One of the most consistent findings across functional neuroimaging studies is the involvement of the reward circuitry in PGD. The seminal work by O'Connor and colleagues revealed that individuals with complicated grief showed unique activation in the nucleus accumbens (NAc) a key reward processing region when viewing photographs of their deceased loved ones [24]. This NAc activation was positively correlated with self-reported yearning but not with time since death or other variables, suggesting a specific connection to the persistent longing characteristic of PGD [25].

This reward-related activation pattern is consistent with the conceptualization of PGD as involving addictive-like craving for the deceased. In PGD, reminders of the deceased may trigger activation in reward circuits that ordinarily respond to pleasurable stimuli, potentially reinforcing rumination about the lost relationship and interfering with adaptation to the loss [26]. As Gang and colleagues note in their systematic review, "Reminders of the deceased may still activate neural rewards for those with PGD... This reward activation may interfere with adapting to the loss in the present" [27].

The reward system in PGD involves not only dopaminergic pathways but also oxytocin and endogenous opioid systems. These neurochemical systems converge in brain regions involved in attachment behavior, particularly the nucleus accumbens. Recent research suggests altered oxytocin signaling in individuals with PGD, though the exact mechanisms remain unclear [28]. A pilot study by Bui and colleagues found that compared to bereaved individuals with primary depression, those with PGD exhibited significantly higher circulating oxytocin levels, potentially reflecting dysregulation in attachment-related neurochemistry [29].

The neurobiological dysregulation in PGD extends beyond reward regions to encompass circuits involved in emotional regulation and self-referential processing. Studies have demonstrated differential patterns of activity in the amygdala, orbitofrontal cortex (OFC), posterior cingulate cortex (PCC), and rostral or subgenual anterior cingulate cortex (ACC) in individuals with PGD compared to those with normal grief [30]. These brain regions form interconnected networks that regulate emotional responses to loss and participate in autobiographical memory processing.



Structural Brain Changes in Prolonged Grief

Beyond functional alterations, emerging evidence suggests that prolonged grief may be associated with structural brain changes. A population-based study by Saavedra Perez and colleagues examined cognitive functioning and brain structure in individuals with complicated grief [31]. Their findings revealed that participants with complicated grief had lower scores on cognitive tests and structural differences in brain regions involved in emotional and cognitive processing.

The neural mechanisms of grief can be understood within the context of learning and adaptation. O'Connor proposes a "gone-but-also-everlasting" model, suggesting that grieving represents a form of learning that requires time and experiential feedback [32]. According to this model, difficulties in adaptation to loss may stem from preexisting vulnerabilities, such as spousal dependency or reduced hippocampal volume, as well as complications that develop after loss, including avoidance, rumination, and stress-induced hippocampal atrophy.

Stress-related mechanisms appear particularly relevant to understanding the structural brain changes associated with prolonged grief. Chronic activation of stress responses following bereavement may contribute to alterations in both gray and white matter structures. The hippocampus, a region critical for contextual learning and memory that is also highly sensitive to stress hormones, may be particularly vulnerable to the effects of unresolved grief [33].

Recent research by Bryant and colleagues using functional MRI has revealed distinct neural mechanisms of emotional processing in PGD [34]. Their findings suggest that individuals with PGD exhibit reduced activity in regions associated with cognitive control over emotional responses, potentially contributing to difficulties in regulating grief reactions.

Implications for Treatment Development

These neurobiological insights have important implications for

treatment development. Given the involvement of opioid systems in attachment and grief, preliminary clinical observations suggest that naltrexone, an opioid antagonist commonly used to treat addiction, may have potential benefits for individuals with PGD. Anecdotal reports describe rapid reduction in PGD symptoms following naltrexone administration, with improvements in functionality and decreased preoccupation with the deceased [35]. This has led to the development of randomized controlled trials investigating naltrexone for PGD treatment.

Additionally, understanding the neural circuits involved in grief processing may help refine existing psychotherapeutic approaches. For example, exposure-based elements of complicated grief therapy may work by facilitating extinction learning in brain networks involved in emotional processing, while cognitive restructuring components may enhance activity in prefrontal regions that support emotional regulation [36].

The distinct neurobiological profile of PGD provides strong support for its classification as a unique diagnostic entity and offers promising avenues for developing targeted interventions. Future research combining multimodal neuroimaging with genetic, inflammatory, and neuroendocrine measures will likely provide a more comprehensive understanding of the biological mechanisms underlying prolonged grief and inform personalized treatment approaches [37].

Assessment Measures

Several validated measures have been developed to assess PGD, including:

International Prolonged Grief Disorder Scale (IPGDS): Specifically designed to assess PGD according to ICD-11 criteria, with demonstrated cross-cultural validity [38].

Prolonged Grief Scale 13 Revised (PG-13-R): Measures symptoms of PGD per DSM-5-TR criteria [39].

Traumatic Grief Inventory Self Report Plus (TGI-SR+): Screens for both PGD per ICD-11 and DSM-5-TR criteria, facilitating research comparing both diagnostic approaches [40].

These tools are valuable for both clinical assessment and research purposes, providing standardized methods for identifying individuals who may benefit from grief-specific interventions.

Differential Diagnosis

Distinguishing PGD from normal grief, depression, PTSD, and adjustment disorder is essential for appropriate treatment planning. While there is some symptom overlap between these conditions, research has consistently supported the distinctiveness of PGD [41].

Normal grief typically diminishes in intensity over time and does not significantly impair functioning in the long term. In contrast, PGD is characterized by persistent, intense grief symptoms that interfere with daily life [42]. Unlike depression, which features pervasive low mood across contexts, the emotional distress in PGD is focused primarily on the loss [43].

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Psychotherapeutic Interventions

Psychotherapy is the mainstay of treatment for PGD. Several evidence-based approaches have demonstrated efficacy:

Prolonged Grief Treatment (PGT): The first treatment specifically developed for PGD, PGT is a 16-session protocol targeting acceptance of the reality of the loss and restoration of capacity for well-being. Its conceptualization is based in attachment theory and understanding of attachment loss as a traumatic stressor [44]. Research has shown that PGT is twice as effective as interpersonal psychotherapy in reducing grief intensity and associated functional impairment [45].

Complicated Grief Treatment (CGT): Drawing from both interpersonal therapy and treatments for PTSD, CGT addresses the unique features of prolonged grief, such as yearning for the deceased. The protocol includes exposure therapy components and focuses on seven core themes. Studies have found that approximately 70% of people with prolonged grief improve with this treatment [46].

Grief-Focused Cognitive Behavioral Therapy (GF-CBT): This approach targets the mechanisms thought to maintain PGD, including painful memories, maladaptive appraisal patterns,

and unhelpful coping behaviors, particularly avoidance of loss reminders. Treatments that include exposure-based processing of memories of the loss have shown superior outcomes [47].

Integrative Cognitive Behavioral Therapy for Prolonged Grief (PG-CBT): This newly developed approach has demonstrated efficacy in randomized controlled trials, showing large pre- to post-treatment effect sizes [48].

These specialized treatments share common elements, including confronting grief-related avoidance, processing painful emotions related to the loss, finding meaning in continuing bonds with the deceased, and re-engaging with life.

Pharmacological Approaches

The evidence for pharmacological treatments specifically targeting PGD remains limited. While antidepressants have not shown significant effects on grief symptoms in controlled trials, it remains to be seen whether they may be helpful for managing comorbid depression [49]. One study found that the addition of an antidepressant to CGT reduced depressive symptoms but did not affect grief outcomes directly [50].

Research on novel pharmacological approaches, including the potential use of naltrexone, is ongoing, but more rigorous studies are needed to establish evidence-based targets for pharmacotherapy in PGD [51].

Spiritual Dimensions of Grief Recovery

It is important to recognize that grief recovery often encompasses dimensions beyond symptom reduction: "A theory of illness requires understanding the patient as a person in process, into whose reality we enter in order to understand how the personality interacts with the dynamics of the illness" [52].

This perspective resonates with the observation that grief is not merely a clinical phenomenon but a deeply human experience with spiritual implications. DeCort reflects this understanding: "Grief must be externalized. Our pain and sadness can be fully realized only when we release them" [53]. This insight aligns with therapeutic approaches that emphasize the importance of expressing grief rather than avoiding it.

The spiritual aspects of grief recovery may include:
Finding meaning in the loss and in continuing bonds with the deceased
Integrating the loss into one's life narrative and identity
Reconnecting with sources of hope, purpose, and community support
Acknowledging the transformative potential of grief experiences

"Spirituality, an innately human construct and force with pervasive influence across the expanse of human experience, organically and fluidly aligns with music as a similarly indigenous facet of human expression and experience" [54]. This suggests that incorporating spiritual practices and expressive arts may enhance conventional therapeutic approaches to grief.

The recent inclusion of PGD in major diagnostic classifications has important implications for clinical practice. Awareness of PGD among general health practitioners and mental health specialists is critical for appropriate early intervention [55]. Screening for PGD risk factors in bereaved individuals may help identify those who could benefit from preventive interventions.

Given the effectiveness of specialized grief-focused therapies, training clinicians in these approaches is essential. Furthermore, the recognition of the spiritual and holistic dimensions of grief recovery suggests the value of interdisciplinary collaboration in supporting bereaved individuals.

Future Research Directions

Several important areas for future research emerge from this review:

Refining diagnostic criteria: Further research is needed to harmonize the ICD-11 and DSM-5-TR criteria for PGD and establish optimal diagnostic thresholds [56].

Treatment development and dissemination: While effective treatments exist, research on enhancing their accessibility and adapting them for diverse populations is needed [57].

Neurobiological mechanisms: Continued investigation of the neurobiological underpinnings of PGD may lead to the development of novel treatment approaches [58].

Integration of spiritual perspectives: Research examining how spiritual practices and beliefs influence grief trajectories and responses to treatment could enhance existing interventions [59].

Long-term outcomes: Longitudinal studies examining the natural course of PGD and long-term treatment effects are essential for understanding the prognosis and optimal duration of interventions [60].

Conclusion

Prolonged grief disorder represents a significant advance in our understanding of pathological grief responses. The inclusion of PGD in major diagnostic classifications acknowledges the reality that for some individuals, grief becomes a persistent, debilitating condition requiring specialized intervention.

Evidence-based treatments, particularly grief-focused psychotherapies, have demonstrated effectiveness in alleviating prolonged grief symptoms and associated functional impairment. However, a comprehensive approach to grief recovery must recognize the multidimensional nature of grief, including its spiritual and existential aspects.

As my work on healing emphasizes, the journey from illness to health often involves more than symptom reduction it encompasses a reintegration of the self and a restoration of meaning and purpose. For those experiencing prolonged grief, this may mean not only accepting the reality of the loss but also finding new ways to carry the relationship with the deceased forward while re-engaging with life.

Future research and clinical practice in this area will benefit from continued dialogue between empirical science and humanistic perspectives on grief and healing, ensuring that our approaches to prolonged grief disorder remain both evidence-based and deeply responsive to the human experience of loss.

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