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Prolonged Grief Disorder: Diagnostic, Assessment, and Treatment Considerations

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Normative bereavement reactions are contrasted with prolonged grief disorder (PGD). Diagnostic criteria for PGD are reviewed. PGD is distinguished from other problems occurring after loss, namely depression and PTSD. Assessment approaches are described. Recent clinical trials are reviewed, and recommendations for the psychotherapeutic treatment of PGD are developed. Consideration of medication referral is also recommended, especially in the case of co-occurring depression.

Keywords: prolonged grief, complicated grief, pathological grief, traumatic grief, psychotherapy

Nearly every life includes the loss of a loved one, and nearly every psychologist's professional life includes encounters with patients for whom such a loss causes unusually prolonged and disabling grief. In this paper, we review the growing literature on prolonged grief disorder (PGD), alternatively called complicated grief, pathological grief, or traumatic grief. We begin with an overview of normative bereavement reactions. We then describe diagnostic criteria for PGD, the distinction between PGD and other disorders, and assessment instruments that can help clinicians identify PGD. Next, we describe treatments that have shown efficacy in reducing PGD symptoms. We conclude by identifying common components of effective treatments and offering recommendations to the practicing clinician.

Normative Bereavement Reactions

Many types of loss can have a profound effect on people's psychological functioning; in this paper, we focus exclusively on adults' reactions to the loss of another person through death. Bereaved individuals often find themselves yearning intensely for the lost loved one. In the weeks and months after a loss, this grief typically begins to abate. The bereaved gradually reengages in pleasurable activities and reattaches to significant others. In a prospective study of individuals followed from before the death of a loved one to 18 months afterward, the most common trajectory, endorsed by 45% of the sample, was one in which depressive symptoms remained low and grief symptoms had largely resolved by 18 months postloss (Bonanno et al., 2002). Less than a quarter of the sample followed trajectories in which they continued to show elevated grief symptoms at the end of the study. Thus, most people eventually arrive at a new emotional equilibrium after loss, without developing any prolonged impairment. Indeed, some healthy individuals do not show significant distress or impairment even shortly after a major loss (Wortman & Silver, 1989).

Although the normal grieving process is not fully understood, one prominent theory holds that healthy grieving typically involves completion of loss-focused tasks and restoration-focused tasks (Stroebe & Schut, 1999). The griever confronts loss stressors when doing things that involve engagement with stimuli that serve as reminders of the reality of the loss, such as looking through old photos of or sharing stories about the deceased. This emotionally taxing work is balanced by periods of withdrawal from loss stressors; the griever's attention oscillates between evocative echoes of the past and present-focused activities (see also Horowitz & Reidbord, 1992). At the same time that the griever learns to cope with doses of loss stressors, he or she also focuses on the restoration of everyday life functions that depended critically on the lost loved one. For example, the bereaved may need to learn how to manage his or her own finances or cooking, and he or she may need to seek out new sources of social and emotional support and companionship. Through the completion of loss- and restoration-focused tasks, the griever is able to come to an acceptance of irrevocably changed circumstances and reengage in life.

Notwithstanding the natural resilience or recovery that most grievers demonstrate, many psychotherapy trials have been aimed at alleviating grief reactions irrespective of severity or

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chronicity. An exhaustive meta-analysis of 61 grief treatment trials found that active psychotherapies produced small to moderate reductions in grief symptoms (e.g., yearning for the deceased) compared with control conditions; however, at long-term follow-up, there was no difference, on average, between outcomes for the treatment and control conditions, with control participants' grief improving with time rather than worsening (Currier, Neimeyer, & Berman, 2008). Regardless of the demographics of the targeted population (e.g., women vs. men), grief therapies generally failed to show any long-lasting benefit for normative grief reactions. Consequently, there is a growing consensus in the field that interventions aimed at redressing normative grief reactions are contraindicated (e.g., Bonanno & Lilienfeld, 2008; Neimeyer, 2000). Defenders of normative grief counseling have argued that there exists little to no peer-reviewed evidence of harm from such treatments (Larson & Hoyt, 2007) and that if such therapy can merely accelerate the natural healing process for most patients, then reducing the duration of grievers' distress and impairment may still be a worthy clinical goal (Hoyt & Larson, 2010). However, even advocates of treatment for normative grief have cautioned that meta-analyses (e.g., Allumbaugh & Hoyt, 1999; Currier et al., 2008) have indicated that universally applied grief treatments (e.g., as found in treatment studies that have used aggressive recruitment procedures) are likely ineffective, and that instead treatment of normal grief should be aimed at self-referred or clinically referred patients (Hoyt & Larson, 2010).

Although there is some debate about the appropriateness of offering treatment to individuals exhibiting normative grief reactions, Currier et al.'s (2008) meta-analysis of grief therapy trials showed clear, substantial, and long-lasting benefits for a subset of individuals, namely those suffering severe and prolonged grief symptomatology. Consequently, there is agreement even among many critics of normative grief treatment (e.g., Bonanno & Lilienfeld, 2008) that intervention is indicated in cases of prolonged grief. We now turn our attention to understanding and identifying PGD before describing treatments that have shown efficacy in treating this problem.

Prolonged Grief Disorder

In PGD, bereavement difficulties persist or grow rather than diminishing with time. The prevalence of PGD varies; studies have found fewer than 10% (e.g., Kersting, Brahler, Glaesmer, & Wagner, 2011) to as many as 20% (e.g., Shear, McLaughlin, et al., 2011) of bereaved individuals developing PGD. Several risk factors have been identified. A history of prior trauma or loss, a history of mood and anxiety disorders, insecure attachment style, being a caregiver for the deceased, a violent cause of death (e.g., suicide), and a lack of social support after the loss predict greater likelihood of developing PGD (e.g., Lobb et al., 2010). These factors appear to predispose individuals toward intense longing for the deceased, thwarting the loss-processing and functional restoration tasks that ordinarily lead to resolution of grief. Failure to fully face the reality of the loss may prolong emotional reactivity to loss reminders, while avoidance of loss reminders, unwillingness to adopt new roles, and an aversion to seeking support from new individuals may constrict a person's behavioral repertoire and prevent him or her from discovering new sources of meaning and pleasure. Disengaged from the social sphere, the bereaved may thus keep his or her attention narrowly fixed on the past and the meaning, pleasure, and intimacy it contained before the loss of the loved one.

Diagnostic Criteria

Although clinicians have long noted the distinctive phenomenology of prolonged grief reactions, rigorous research on the clinical features of PGD has accumulated only over the last 2 decades, and previous editions of the International Classification of Diseases (ICD) and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) have not included diagnoses corresponding to prolonged grief problems. Instead, they have included "Z" or "V" codes acknowledging bereavement as a possible focus of clinical attention or as a reason that individuals may seek mental health care.

A working group for the next edition of the ICD recently recommended adding a diagnosis of PGD to ICD-11 (Maercker et al., 2013). The group recommended diagnostic criteria (see Table 1) based on an interview study of nearly 300 bereaved individuals that used state-of-the-art psychometric validation methods to identify the central distinguishing clinical features of PGD (Prigerson et al., 2009). The recently released *DSM-5* (American Psychiatric Association, 2013) also includes a diagnostic code corresponding to prolonged grief problems—Other Specified Trauma- and Stressor-Related Disorder, Persistent Complex Bereavement Disorder (PCBD)—with criteria for this diagnosis contained in the section of the manual devoted to conditions needing further study. The working criteria (see Table 1) draw in part on the validation study informing the proposed ICD-11 criteria (Prigerson et al., 2009) as well as a further study of nearly 800 bereaved individuals' symptoms (Simon et al., 2011). Although there is overlap between the *DSM-5* diagnosis of PCBD and the proposed ICD-11 diagnosis of PGD, critics have voiced concern that some of the symptoms unique to the *DSM-5* diagnosis (e.g., difficulty positively reminiscing about the deceased) do not have empirical support as markers of dysfunctional grief, there is less evidence supporting the 12-month compared with the 6-month criterion, and the *DSM-5* diagnosis is enormously heterogeneous (e.g., Boelen & Prigerson, 2012). A future revision of the *DSM-5* that finalizes the criteria for PCBD and moves the diagnosis to the main section of the manual may address these and other issues. In the meantime, should clinicians prefer to use the proposed ICD-11 criteria for diagnosing PGD, one option for those working in settings that require *DSM-5* diagnoses is to use the Unspecified Trauma- and Stressor-Related Disorder diagnosis for cases that do not meet the PCBD working criteria but do meet the proposed ICD-11 PGD criteria.

PGD Versus Other Disorders

The disruption associated with bereavement can trigger various disorders, including not only PGD but also major depression and posttraumatic stress disorder (PTSD). Empirically, PGD has been shown to be a distinctive syndrome apart from ordinary grief, major depression and other mood disorders, and PTSD and other anxiety or stress-related disorders (Barnes, Dickstein, Maguen, Neria, & Litz, 2012; Boelen & van den Bout, 2008; Bonanno et al.,

Table 1
Diagnostic Criteria for ICD-11 Prolonged Grief Disorder (Proposed) and DSM-5 Persistent Complex Bereavement-Related Disorder

ICD-11 Prolonged Grief Disorder	*DSM-5* Persistent Complex Bereavement-Related Disorder
A. Death of a close other B. Yearning for the deceased daily or to a disabling degree C. Five or more of the following daily or to a disabling degree: 1. Confusion about one's role in life or diminished sense of self 2. Difficulty accepting the loss 3. Avoidance of reminders of the reality of the loss 4. Inability to trust others since the loss 5. Bitterness or anger related to the loss 6. Difficulty moving on with life (e.g., making new friends, pursuing interests) 7. Emotional numbness since the loss 8. Feeling that life is unfulfilling, empty, or meaningless since the loss 9. Feeling stunned, dazed, or shocked by the loss D. At least 6 months have passed since the death E. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning F. The disturbance is not better accounted for by major depressive disorder, generalized anxiety disorder, or posttraumatic stress disorder.	A. Death of a close other B. Since the death, at least one of the following on most days to a clinically significant degree for at least 12 months after the death: 1. Persistent yearning for the deceased 2. Intense sorrow and emotional pain in response to the death 3. Preoccupation with the deceased 4. Preoccupation with the circumstances of the death C. Since the death, at least six of the following on most days to a clinically significant degree for at least 12 months after the death: 1. Marked difficulty accepting the death 2. Disbelief or emotional numbness over the loss 3. Difficulty with positive reminiscing about the deceased 4. Bitterness or anger related to the loss 5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame) 6. Excessive avoidance of reminders of the loss 7. A desire to die to be with the deceased 8. Difficulty trusting other people since the death 9. Feeling alone or detached from other people since the death 10. Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased 11. Confusion about one's role in life or a diminished sense of one's identity 12. Difficulty or reluctance to pursue interests or to plan for the future (e.g., friendships, activities) since the loss D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning E. The bereavement reaction must be out of proportion or inconsistent with cultural or religious norms

Note. Proposed criteria for ICD-11 PGD are from Prigerson et al. (2009), referenced in Maercker et al. (2013). Criteria for *DSM-5* PCBD are from the American Psychiatric Association (2013).

2007; Prigerson et al., 1996; Shear, Simon, et al., 2011). For example, a factor analysis of symptoms in 150 widowed individuals, 6 months after their partners' deaths, found that PGD symptoms loaded poorly on depression and anxiety factors (Prigerson et al., 1996), a result that has been repeatedly replicated in studies of the bereaved (e.g., Boelen & van den Bout, 2005). Moreover, at least one risk factor, separation anxiety in childhood, uniquely predicts PGD but not major depressive disorder, generalized anxiety disorder, or PTSD (Vanderwerker, Jacobs, Parkes, & Prigerson, 2006). Furthermore, even after adjusting for co-occurring depression and PTSD, PGD is associated with reduced quality of life, social and occupational impairment, sleep disturbance, substance use problems, increased risk of cardiac events and cancer, and suicidal thoughts and behaviors (Bonanno et al., 2007; Latham & Prigerson, 2004). Finally, although comorbidity is common, PGD can occur in isolation. In one sample of individuals diagnosed with PGD, approximately half also had current depression, and about half had current PTSD, but in 80% of these cases, the depression or PTSD predated the PGD, and in one quarter of patients with PGD there were no co-occurring *DSM–IV* Axis I disorders (Simon et al., 2007).

In conceptually distinguishing PGD from major depression, a key consideration is the extent to which certain symptoms are specifically about the loss of the loved one (PGD) versus free-floating and generalized (depression). Compared with the pervasive misery and pessimistic rumination of depression, the dysphoria of PGD is focused on separation from the deceased, and the primary alteration in cognition is intense preoccupation with the lost loved one. Likewise, global guilt or a sense of personal worthlessness, common in depression, is not part of PGD, although there may be inappropriate self-blame specifically concerning the death. Whereas depression often entails a broad loss of interest and inability to imagine any source of pleasure, in PGD there is a sustained interest in the deceased and belief that reunion with the deceased would bring satisfaction. In addition, PGD involves particular avoidance of stimuli that serve as reminders of the reality of the loss compared with the more general avoidance and withdrawal of depression. Thus, even apart from the several features of depression that are entirely distinctive from PGD criteria (e.g., weight or appetite change, sleep disruption, psychomotor retardation or agitation, fatigue, diminished concentration) and the features of PGD that are distinctive from depression (e.g., confusion about one's role in life, difficulty accepting the loss, inability to trust others since the loss), it is possible to distinguish the disorders in terms of the nature of the negative emotions and thoughts that characterize each problem.

A central conceptual distinction between PGD and PTSD is the dominant emotions associated with each disorder. Whereas PTSD is characterized typically by fear, horror, anger, guilt, or shame, combined with an anxious hyperarousal and exaggerated reactivity, the experience of PGD is marked primarily by yearning, loss, or emptiness. Moreover, with PTSD after a loss, intrusive thoughts are fixated on the death event itself and involve a sense of threat, leading individuals to avoid internal and external reminders of the

death event; on the other hand, in PGD, individuals may experience intrusive and voluntary thoughts about diverse aspects of the relationship with the deceased, including positive content that the bereaved longs for, and avoidance is mostly limited to those stimuli that serve as reminders of the reality or permanence of the loss. As with major depression, several other features of PTSD are quite distinctive from those of PGD (e.g., nightmares, flashbacks, aggression), but there is some overlap between the disorders (e.g., emotional numbing since the time of the loss, shared by PGD and PTSD), and clinicians must be careful not to assume that the presence of one loss-related disorder implies the absence of another.

Assessment Instruments

One large study of general psychiatric outpatients found that over one third of individual seeking mental health care exhibited at least moderate levels of PGD symptoms (Piper, Ogrodniczuk, Azim, & Weideman, 2001). Therefore, assessing for unresolved grief in patients presenting with other complaints may be a wise clinical practice even when time does not permit a full interview probing formal diagnostic criteria. Reliable self-report inventories are available. The Inventory of Complicated Grief (ICG; Prigerson et al., 1995) is the instrument that has been most commonly used to identify clinical levels of PGD symptoms in research. It consists of 19 statements about grief-related thoughts and behaviors (e.g., "I feel I cannot accept the death of the person who died"; "I feel myself longing for the person who died") with five response options indicating different levels of symptom severity. In accordance with diagnostic guidelines for PGD, the ICG should be administered at least 6–12 months after the death of a loved one. Across samples, the ICG has shown good internal consistency, test–retest reliability, and prediction of impairment beyond what can be accounted for by general mood and anxiety problems. A total score of above 25 or 30 has been considered suggestive of PGD. More recently, the ICG has been distilled into the Prolonged Grief 13 (PG-13), a collection of the ICG's most informative and unbiased items (Prigerson et al., 2009).

In primary care and other settings in which time is scarce, an even briefer instrument, the Brief Grief Questionnaire (BGQ; Ito et al., 2012), may be useful. The BGQ asks patients to report symptom severity on a 3-point scale for each of five grief symptoms (e.g., "How much does grief still interfere with your life?"; "How much are you having trouble accepting the death of _____?"). The instrument showed good psychometric properties in a large Japanese sample (Ito et al., 2012) and a U.S. sample (Shear, Jackson, Essock, Donahue, & Felton, 2006), suggesting that PGD symptoms can be assessed using minimal resources and that the measurement of PGD is not strongly culturally bound. A score of 5 to 7 on the BGQ is considered suggestive of subthreshold prolonged grief, whereas at a score of 8 or higher, PGD is considered likely (Shear et al., 2006).

When PGD is present, careful assessment of risk is essential. PGD has been associated with a 6 to 11 times greater risk of suicidality even after controlling for other risk factors such as depression and PTSD (Latham & Prigerson, 2004). Standardized instruments such as Beck's Scale for Suicidal Ideation (Beck, Kovacs, & Weissman, 1979) and the Yale Evaluation of Suicidality Scale (Latham & Prigerson, 2004) are available to aid clinicians in assessing suicide risk.

Treatments for PGD

Pharmacotherapy

Some case series and open-label trials have suggested that selective serotonin reuptake inhibitor antidepressants may help in PGD (Bui, Nadal-Vicens, & Simon, 2012; Simon, 2013). On the other hand, a randomized controlled trial found a tricyclic antidepressant to be ineffective for grief reduction, even while it exerted a powerful effect on major depressive symptoms in the bereaved (Reynolds et al., 1999). Until further evidence from controlled trials is adduced, the role of pharmacotherapy in treating PGD will remain unclear. Some experts have suggested that pharmacotherapy may be a useful adjunct to psychotherapy in the treatment of PGD (e.g., Simon, 2013); studies testing this combined approach are ongoing.

Psychotherapy

In a meta-analysis of randomized controlled trials of psychotherapy for adults with PGD, cognitive–behavioral grief-targeted interventions were found to be more effective than control conditions (i.e., supportive or other nonspecific therapy, or waitlist) for reducing PGD symptoms (Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). Moreover, treatment effects for these therapies grew larger at follow-up. In our review of PGD psychotherapies, we emphasize those that have received strong support in randomized controlled trials, but we also describe other therapies that have a more limited base of empirical support at present. In the absence of a consensus set of PGD diagnostic criteria, studies have varied somewhat in their inclusion criteria; therefore, variations in outcomes may be due in part to variations in the severity of PGD that characterized each study sample.

Individual psychotherapy. In a pioneering study, almost 100 women and men received 16 sessions of either interpersonal therapy—a treatment that is effective for depression—or a multifaceted treatment explicitly tailored to target PGD (Shear, Frank, Houck, & Reynolds, 2005). A larger proportion of participants receiving the grief-specific therapy responded favorably to treatment compared with those receiving the interpersonal therapy, and grief symptoms showed faster reduction in the grief therapy condition; differences in symptom reduction between conditions were medium in effect size. Pilot studies have suggested that the therapy used in this study may be efficacious in diverse populations diagnosed with PGD, including individuals with comorbid substance use disorders (Zuckoff et al., 2006) and bereaved individuals in non-Western cultural contexts (Asukai, Tsuruta, & Sait, 2011).

The therapy designed by Shear and colleagues (2005) included several components that encouraged patients to address the loss- and the restoration-focused tasks of grieving (Stroebe & Schut, 1999). Key therapeutic work occurred during the 1-hr weekly sessions and in homework assignments completed between sessions. The introductory phase of treatment focused on psychoeducation about grief, emphasizing the importance of processing the loss and restoring life functioning and purposeful engagement that

may have ceased in the wake of the loss. Patients shared history, including history of the relationship with the deceased, and brainstormed current life goals or aspirations. With this preparatory work completed, patients then engaged in the loss-focused exercise of vividly narrating, with eyes closed, the death of the loved one ("revisiting"). Modeled after imaginal exposure in prolonged exposure treatment for PTSD, this in-session revisiting exercise was audio-recorded, and patients listened to the recording at home. Loss-focused exercises also included an imaginal conversation with the deceased and writing about and discussing positive and negative memories featuring the loved one. Restoration-focused exercises centered on creating and executing concrete plans for moving toward valued life goals and restoring pleasant activities. Patients were also encouraged to approach situations that had been avoided because they served as loss reminders, similar to in vivo exposures in PTSD treatment. Throughout the treatment, cognitive restructuring was used when unhelpful grief-related thoughts emerged (e.g., inappropriate self-blame for the death, or a belief that moving forward from grief would dishonor the deceased).

Another individual psychotherapy that has shown comparable efficacy for PGD combines exposure and cognitive restructuring components (Boelen, de Keijser, van den Hout, & van den Bout, 2007). In a study of bereaved individuals in the Netherlands, patients with PGD were assigned to receive 6 weeks of exposure therapy followed by 6 weeks of cognitive restructuring, 6 weeks of cognitive restructuring followed by 6 weeks of exposure therapy, or 12 weekly sessions of supportive counseling. Participants in both of the cognitive–behavioral treatment conditions showed greater clinical improvement on all measures compared with those who received supportive counseling. Comparisons between the cognitive–behavioral conditions suggested that the exposure component of treatment produced greater symptom improvement than the cognitive component. In this study, exposure consisted of repeated retelling of the story of losing the loved one with an emphasis on the most emotionally distressing parts (a loss focus) and building a hierarchy of avoided stimuli and contexts that serve as reminders of the loss, followed by graduated confrontation with these stimuli and experiences (a restoration focus). The cognitive restructuring component involved learning to identify and challenge negative thoughts that occurred naturally during everyday life.

Recent research has examined the efficacy of PGD treatment with an exclusive restoration focus. In a randomized open-label trial, participants who received 12–14 weekly behavioral activation therapy sessions showed large reductions in grief symptoms compared with those in a waitlist control condition (Papa, Sewall, Garrison-Diehn, & Rummel, 2013). The therapy was based on manualized behavioral activation for depression, with minor modifications to tailor the treatment to PGD. In particular, participants were educated about how PGD can involve and be maintained by the strategic avoidance of cues related to the loss; next they engaged in the phases of self-monitoring, functional analysis, and engagement in reinforcing activities that constitute the core of standard behavioral activation. The therapy included no loss-processing or cognitive restructuring components. In an uncontrolled trial, Acierno et al. (2012) found that an even further pared-down treatment—five weekly sessions of behavioral activation, two of them conducted by telephone—also produced large reductions in grief symptoms. To test whether PGD treatment could be effective given the constraints of many community settings, therapists in this trial ranged widely in experience level, and the therapy manual they followed was limited to a single page. The principal intervention in this trial was the assignment for participants to complete 3 hr daily of positively and negatively reinforcing activities with at least 30 min devoted to activities that may serve as loss reminders. Wherever possible, participants were encouraged to complete their activities in a social setting to facilitate the natural restoration of social relationships.

In all of these individual trials for PGD, attrition was substantial but similar to other psychotherapy trials. In the Shear et al. (2005) trial, 27% of participants dropped out of the PGD therapy; in the Boelen et al. (2007) trial, dropout rates were 20% and 30% for the two active treatments; and dropout was 20% in Papa et al.'s (2013) behavioral activation treatment. Further analyses of the Shear et al. (2005) trial suggested that medication may help some patients to tolerate treatment. Dropout from PGD therapy was only 9% for patients who were taking antidepressants during the treatment course, whereas 42% of unmedicated patients dropped out (Simon et al., 2008).

Group psychotherapy. Can PGD symptoms be addressed through group psychotherapy? In a trial involving German psychiatric inpatients with comorbid PGD, a twice-weekly group therapy (added on to treatment as usual), delivered over a total of nine sessions, led to a large reduction in PGD symptoms compared with treatment as usual (Rosner, Lumbeck, & Geissner, 2011). The group therapy drew on common elements of individual PGD therapies that had shown efficacy in other trials (e.g., Shear et al., 2005). Key components included psychoeducation about the grieving process, confronting the loss (including a written exercise), building motivation for change, understanding and reducing avoidance, and challenging unhelpful thoughts. One major strength of this study was the complex study group examined; patients were drawn from three different inpatient wards targeting primary anxiety disorders, somatoform disorders, and eating disorders, respectively, and each participant had an average of 2.5 diagnoses in addition to PGD. Moreover, treatment as usual in this inpatient setting was highly intensive, including individual and group psychotherapy sessions, social skills training, physical therapy, medical consultations, and other indicated treatments such as biofeedback. Thus, the efficacy of the brief experimental group therapy, compared with treatment as usual, in this naturally treatment-seeking population bodes well for the real-world effectiveness of psychotherapy designed specifically for PGD.

Two additional trials have provided evidence for the efficacy of group psychotherapy for PGD modeled after Shear et al.'s (2005) individual therapy. In a treatment study of bereaved adults over the age of 60, participants were assigned to receive 16 weekly sessions of treatment as usual (a general grief support group) or a specialized PGD group therapy (Supiano & Luptak, in press). Participants receiving the experimental and the control group therapies both showed improvement, but the specialized PGD therapy led to a significantly greater reduction in grief symptoms. Furthermore, in an uncontrolled 10-week group treatment trial that also included psychoeducation, cognitive restructuring, emotional processing of loss, and restoration of positive activities, participants showed significant reductions in grief symptoms (Maccullum & Bryant, 2011).

Breaking from the cognitive–behavioral approaches that most therapy trials for PGD have taken, Piper and colleagues (2001, 2007) compared interpretive psychodynamic group therapy to supportive group therapy. In a randomized controlled trial of 12-week group therapies for PGD, 139 participants were assigned to either a manualized interpretive intervention or a present-centered supportive therapy (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001). The interpretive therapy focused on increasing patients' insight into patterns of conflict and loss in their lives, and increasing their tolerance for their emotionally complex and sometimes ambivalent reactions to their losses. The supportive condition centered on praising patients' current coping efforts and helping them to adapt to their new circumstances after losing a loved one. Participants in the interpretive and supportive conditions showed equivalent improvements in their grief symptoms. In a second trial involving 110 participants, similar results were again obtained for the interpretive and supportive group therapies, with patients in each condition improving equally (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007).

Internet-based intervention. Another treatment modality that holds promise for alleviating PGD is based on the Internet. In a sample composed mostly (61%) of parents grieving the loss of a child, participation in a 5-week e-mail-based intervention led to a large reduction in PGD symptoms compared with a waitlist control group (Wagner, Knaevelsrud, & Maercker, 2006). Gains were maintained at 18-month follow-up (Wagner & Maercker, 2007), and similar results were achieved when this treatment was given to parents grieving the loss of a pregnancy (Kersting et al., 2013). In this treatment, participants completed twice-weekly writing assignments and communicated by e-mail with a therapist who provided tailored guidance and feedback in response to each assignment. Writing assignments proceeded in three phases. First, in an exposure exercise, participants wrote vivid accounts of the circumstances of the death, and they elaborated on distressing thoughts and emotions surrounding the event. Second, to bolster self-compassion, they wrote supportive letters to a hypothetical friend in the same situation, and to begin thinking about the possibility of moving forward in life, they wrote to the hypothetical friend about how the deceased could be remembered in positive ways while also engaging in new, meaningful activities. Third, participants synthesized what they had learned from the first two phases by writing about memories of the loved one, the meaning of the loss, and how they intended to cope as they continued on with their lives.

Implications for Clinical Practice

Although most people with PGD unfortunately do not seek clinical help (Lichtenthal et al., 2011), the addition of diagnoses related to the disorder in the ICD-11 and *DSM-5* may bring more public attention to PGD and may increase the number of individuals seeking mental health services specifically for PGD. Regardless of the degree to which public awareness of PGD rises, it is important for psychologists who provide mental health care to familiarize themselves with the disorder and for training programs to ensure that trainees learn to recognize and treat PGD. Many millions of people are bereaved every year, and a significant minority of these individuals go on to develop PGD, a disorder associated with functional impairment, reduced quality of life, and increased morbidity and mortality (Bonanno et al., 2007; Latham & Prigerson, 2004).

Many mental health outpatients exhibit symptoms of PGD (Piper et al., 2001) regardless of presenting complaint, and clinicians may wish to add a brief measure of PGD symptoms to any self-report instruments they typically administer to patients at intake. For these purposes, the ICG (Prigerson et al., 1995) or the BGQ (Ito et al., 2012) would be appropriate. Should patients endorse elevated symptoms of depression or PTSD in addition to PGD, key questions can help the clinician to distinguish the primary problem. First, does the patient's emotional distress (e.g., sadness, guilt) specifically have the loss of a loved one as its object (PGD), or is it more pervasive across all domains of life (depression)? Second, does the patient think obsessively, voluntarily and involuntarily, about many aspects of the lost relationship with the loved one, and does this thinking mainly produce yearning for the deceased (PGD), or are the patient's recurring thoughts exclusively intrusive and focused on the death event itself, mainly leading to fear or anxiety (PTSD)?

When PGD symptoms are pronounced and appear to be the most appropriate focus of clinical attention for a patient, and at least 6–12 months have passed since the death of the loved one, individual or group psychotherapy targeting PGD should be considered. Research suggests that some treatments that are helpful for depressive symptoms, such as interpersonal psychotherapy and antidepressant medication, are not as effective as specialized treatments for ameliorating PGD (e.g., Reynolds et al., 1999; Shear et al., 2005). Although trials of specialized treatments for PGD are still limited in number, have varied somewhat in inclusion criteria for this new diagnosis, and have shown substantial attrition (similar to other therapy trials), the existing evidence base is sufficient to offer psychotherapy recommendations. Treatment manuals for PGD are not yet widely available, but clinicians with competence in cognitive–behavioral principles and therapeutic techniques of exposure, behavioral activation, and cognitive restructuring should be able to implement the core components shared by efficacious PGD treatments (e.g., Boelen et al., 2007; Papa et al., 2013; Rosner et al., 2011; Shear et al., 2005.; Wagner et al., 2006). These core components include psychoeducation about grief; encouraging repeated, emotionally evocative processing of the reality of the loss in written or oral form; promoting social reengagement, including activities avoided because they serve as loss reminders; helping the patient to identify new aspirations that imbue life with meaning; and teaching the patient to challenge unhelpful thoughts that inhibit completion of the aforementioned tasks.

However, in the absence of dismantling studies, it is not clear which components of psychotherapy are necessary for the clinical improvements seen in PGD treatment trials using complex psychotherapy packages, and it is possible that some treatment components are inert. For example, in the Shear et al. (2005) intervention, which has influenced other treatments for PGD, there is no evidence to support the assumption that the moment of death is the most distressing and haunting experience for all bereaved individuals or that repeated exposure to memories of the moment of death results in extinction of negative affect, especially sadness (see Steenkamp et al., 2011). The imaginal exposure procedures in this and other treatments may stem from an untested assumption that the etiology of PGD is similar to traumatic conditioning. Imaginal exposure therapies target discrete fear-based episodic memories;

because PGD is not characterized by fearful memories, the therapeutic rationale for repeated and sustained reliving of the moment of death is unclear. Moreover, there is no evidence that "working through" a loss by sustained focus on it is necessary for healing for all individuals (Wortman & Silver, 1989), even if it may be a common part of the normal grieving process (Stroebe & Schut, 1999).

Therefore, we recommend that rather than emphasize repeated exposure to the death, clinicians should look first to the restoration-focused aspects of PGD treatment. These are the parts of PGD treatments that resemble behavioral activation and involve increasing engagement with the outside world—including stimuli that have been avoided because they serve as reminders of the loss—and encouraging social reintegration. Indeed, although no high-quality randomized controlled trials of behavioral activation for PGD have been published, two small trials have suggested that this intervention, with minimal modifications from behavioral activation for depression, may be sufficient to significantly alleviate PGD symptoms (Acierno et al., 2012; Papa et al., 2013). Clinicians without training in this type of intervention should consider referral to another therapist with appropriate competence (American Psychological Association, 2002). In addition, clinicians should consider a referral for medication management because antidepressant medication may help to treat co-occurring depressive symptoms and may make psychotherapeutic treatment of PGD more tolerable for patients, although the efficacy of medication for grief symptoms themselves is currently unproven (Simon et al., 2008).

Recent research indicates that PGD can be identified as a distinctive disorder and that psychotherapy can reduce PGD symptoms. Our aim in this review has been to encourage clinicians to translate this research into practice. As PGD treatment gains mainstream acceptance within professional psychology, we hope that practitioners will track outcomes and identify implementation barriers to inform further research to improve the effectiveness of therapies for this challenging disorder.

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