



# Beyond Twelve Months: Prolonged Grief Disorder and the Pathologization of Ongoing Loss

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## Abstract

The fifth edition, text revision, of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) introduced prolonged grief disorder (PGD), establishing that grief persisting with sufficient intensity beyond twelve months from a death may constitute a mental disorder. This article advances a conceptual sociology-of-diagnosis critique of the twelve-month criterion. The argument proceeds along three strands. Conceptually, the criterion inherits a teleological model of mourning whose empirical foundations have been substantially undermined by prospective research on bereavement trajectories. Sociologically, the diagnosis participates in a broader medicalization of bereavement that generates self-stigma, disenfranchises socially unsanctioned grief, and erodes cultural mourning practices. Contextually, the criterion presupposes a discrete past loss and so fails most acutely in ongoing-loss situations such as progressive illness and dementia caregiving, where loss has no terminus from which a clock could run. The article engages the strongest clinical case for the diagnosis and the manual's own distress-and-impairment requirement, arguing that neither dissolves the sociological concern. It concludes that the persistence of grief is not, in itself, evidence of disorder.

## Subject Areas

Psychiatry & Psychology

## Keywords

Prolonged Grief Disorder, DSM-5-TR, Medicalization, Bereavement, Pathologization, Disenfranchised Grief, Sociology of Diagnosis, Ongoing Loss

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## 1. Introduction

Contemporary grief theory and clinical practice have long been organized around a teleological assumption: that mourning is a problem to be resolved, a wound that heals, or a developmental task brought to completion. This assumption—termed here the resolution paradigm—traces to Freud’s account of mourning as the gradual withdrawal of attachment from a lost object [1], and it was subsequently formalized in the stage theory of Kübler-Ross [2] and the task models of Worden [3]. Its most consequential contemporary expression is nosological: the fifth edition, text revision, of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) introduced prolonged grief disorder (PGD) as a formal diagnostic category [4], establishing that grief persisting with sufficient intensity beyond twelve months from the death of a loved one may constitute a mental disorder [5].

The introduction of PGD has been defended as a response to genuine clinical need—the identification of a minority of bereaved persons whose grief is genuinely disabling [5]. This article does not dispute that such a need exists. It advances, rather, a sociology-of-diagnosis critique of the twelve-month criterion and the assumptions it encodes, arguing that the diagnosis as constructed risks pathologizing proportionate responses to loss, and that this risk is most acute precisely where loss is continuous rather than located in the past.

A word on method is therefore in order. This is a conceptual, theory-building paper in the tradition of the sociology of diagnosis, not a systematic review or an empirical study; its claims are interpretive and are offered as an argument to be weighed rather than as findings to be replicated. The literature it draws on was selected purposively to serve that argument: foundational statements of the resolution paradigm and its successors; the prospective bereavement research that bears most directly on the assumption of a normative timeline; the principal validation and conceptual statements of the PGD criteria themselves; and the established sociological literature on medicalization, stigma, and disenfranchised grief. Sources were chosen for their centrality to each of these debates rather than through exhaustive database search, and the contextual cases in Section 6 are drawn from the ongoing-loss settings in which the criterion’s application is most contested. The aim is analytic clarity about what the criterion assumes and where those assumptions fail, not a quantitative synthesis of the field.

The argument proceeds along three strands. The first is conceptual: the criterion inherits a teleological model of mourning whose empirical foundations have been substantially undermined. The second is sociological: the diagnosis participates in a broader medicalization of bereavement [6] that carries identifiable costs—self-stigma [7], the disenfranchisement of socially unsanctioned grief, and the erosion of cultural mourning practices [8]. The third is contextual: the twelve-month criterion presupposes a discrete, past loss and therefore fails most acutely in ongoing loss contexts, where the loss has no terminus. Sections 2 and 3 develop the conceptual critique; Sections 4 and 5 develop the sociological critique; Section

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6 develops the contextual critique; Section 7 engages the strongest case for the diagnosis and delimits the scope of the argument, distinguishing legitimate clinical intervention from diagnostic overreach.

## **2. The Resolution Paradigm: Historical Foundations of a Teleological Assumption**

The twelve-month criterion does not arise in a theoretical vacuum. It is the nosological crystallization of a century-old model of how grief is supposed to work. Recovering that lineage is necessary to see what the criterion assumes and why those assumptions matter for the contexts in which the criterion is now applied.

### **2.1. Freudian Decathexis and the Grief-Work Hypothesis**

The theoretical ground for the resolution paradigm was laid by Freud's account of mourning as libidinal withdrawal—a gradual relinquishment of attachment to the lost object that, once complete, frees the bereaved to form new attachments [1]. The account is explicitly processual and teleological: mourning is work with an endpoint, and its completion is the marker of health. From this premise descended the grief-work hypothesis, the clinical commonplace that recovery requires the bereaved to confront and “work through” the loss, and that failure to do so produces pathology. The hypothesis has proven remarkably durable in clinical lore even as its empirical support has weakened [9].

### **2.2. Stage and Task Models**

Freud's processual logic was subsequently elaborated into the stage and task models that still dominate popular and much professional understanding. Kübler-Ross's five stages, though originally proposed to describe the dying rather than the bereaved, were widely transposed into a normative sequence through which grief was expected to pass [2]. Worden recast the same teleology as a set of tasks to be accomplished [3]. Both share the assumption the criterion later inherits: that grief follows, or ought to follow, an ordered movement toward a terminus, such that its persistence past an expected point becomes a sign of disorder rather than a possible form of fidelity.

### **2.3. Continuing Bonds and the Persistence of the Resolution Assumption**

The most influential challenges to the resolution paradigm came from within grief theory itself. The continuing-bonds literature set out expressly to overturn the Freudian mandate: Klass and colleagues argued that maintaining an ongoing relationship with the deceased is a normative and often adaptive feature of bereavement rather than evidence of arrested mourning [10]. Reflecting on the project a decade later, Klass recalled that the aim had been to show “that interacting with the dead could be normal rather than pathological” [11]. The corrective was real and important.

Yet even these correctives can retain, in places, a residual orientation toward adjustment as the criterion of a bond's value. Root and Exline, reviewing the continuing-bonds evidence, observe that the field has had to distinguish bonds that aid adaptation from those associated with poorer outcomes—a distinction that still evaluates the bond partly by its contribution to moving forward [12]. Neimeyer's meaning-reconstruction program likewise frames the central work of grief as the restoration of a coherent self-narrative disrupted by loss [13], and the Dual Process Model, for all its emphasis on oscillation rather than linear progress, describes a coping process oriented over time toward a restored equilibrium [14]. The point is not that these frameworks reinstate Freudian decathexis—they explicitly reject it—but that the assumption of an expectable movement toward adjustment is more deeply sedimented in grief theory than the break with Freud alone would suggest. That sedimentation is what makes a temporal criterion feel intuitive even to clinicians who have abandoned stage theory.

### **3. The Empirical Challenge to the Resolution Trajectory**

#### **3.1. Trajectory Heterogeneity**

If the resolution paradigm rests on the premise that grief of normal intensity diminishes along a predictable timeline, prospective bereavement research has substantially undermined that premise. Bonanno and colleagues, in a prospective study that assessed individuals before as well as after loss, found not a single normative trajectory but several distinct ones, with a resilient pattern—relatively low and stable distress throughout—describing close to half the bereaved rather than a rare minority [15]. Earlier integrative work had already cautioned that the field's assumptions about necessary distress and required “working through” outran the evidence [16]. The empirical examination of the stage model found that its predicted ordering of grief indicators received, at best, weak support [17]. Taken together, these findings give little warrant for treating any single timeline as normative and considerable warrant for expecting heterogeneity—a finding directly at odds with a criterion that reads persistence past a fixed interval as presumptively disordered.

#### **3.2. The Self That Does Not Heal**

A second body of work challenges not the timeline but the underlying image of grief as the management of an external relationship. Charmaz's account of the loss of self in chronic illness describes suffering that dismantles the self that sustained the relationship rather than leaving an intact subject to process an external event [18]. C.S. Lewis, writing from inside bereavement, reached for the image of an amputation that never fully heals—the leg is gone, and the man learns to get about on crutches, but he never becomes a man with two legs again [19]. Frank's typology of illness narratives names the structural problem precisely: the restitution narrative, in which illness leads back to health, is simply unavailable to those whose loss does not reverse, leaving the chaos and quest narratives as the only

honest forms [20]. The irony is that the PGD criteria themselves register this dissolution: among the diagnostic indicators is identity disruption, the sense that part of oneself has died [5]. The resolution paradigm's own instrument thus names the very remaking of the self that it elsewhere treats as a symptom to be corrected.

## **4. Prolonged Grief Disorder and the Twelve-Month Criterion**

### **4.1. The Criterion and Its Encoded Assumption**

The DSM-5-TR criteria for PGD center on persistent, intense yearning or longing for the deceased person, or preoccupation with them, accompanied by a cluster of additional symptoms, present to a clinically significant degree at least twelve months after the death for adults [4]. The temporal threshold is not incidental; it is the operational heart of the diagnosis, the criterion that converts a recognizable human condition into a codable disorder. The criteria's architects state plainly that the twelve-month interval was chosen in order to be sensitive to public concern about pathologizing normal grieving [5].

That stated rationale is revealing. It concedes that the boundary between disorder and proportionate sorrow is a matter of where a line is drawn on a temporal continuum, not a natural kind discovered in the phenomena. A threshold selected partly to manage public concern is a threshold acknowledged to be, in part, a social artifact rather than a purely clinical one. What the criterion encodes is precisely the teleological assumption traced in Sections 2 and 3—that grief of normal intensity should diminish along a predictable timeline, such that persistence past the threshold becomes clinically suspect. The empirical record reviewed above gives little warrant for treating any single timeline as normative.

### **4.2. The Distress-and-Impairment Requirement**

A natural objection is that the criterion does not, in fact, pathologize ordinary grief, because the diagnosis additionally requires that the symptoms cause clinically significant distress or impairment in functioning and that they exceed expected social, cultural, or religious norms for the individual's context [4]. This requirement is a genuine safeguard, and the present critique does not ignore it. It does, however, contend that the safeguard is insufficient to do the work asked of it, for three reasons.

First, distress is intrinsic to proportionate grief, not a marker that distinguishes disorder from health. Profound sorrow over a continuing loss is distressing by its nature; a person caring for a spouse disappearing into dementia is in real anguish whether or not that anguish is pathological. A criterion that triggers on clinically significant distress will therefore capture much grief that is painful precisely because the love and the loss are real, and the distress requirement cannot by itself sort the proportionate from the disordered. Second, functional impairment is frequently a feature of the loss situation rather than of any disorder within the griever: the dementia caregiver who withdraws from work and social life is responding rationally to caregiving demands and to a continuing loss, yet that with-

drawal reads as impaired functioning against a baseline of pre-loss life. Third, the proviso that symptoms must exceed cultural and religious norms places the burden of cultural calibration on individual clinical judgment at the point of diagnosis, in precisely the cross-cultural conditions where, as Section 5 argues, that judgment is least reliable. The distress-and-impairment requirement thus narrows the category at its edges without resolving the core problem: it still leaves the calendar, rather than a positive account of what disordered grief is, doing the central discriminating work.

### **4.3. The Bereavement Exclusion and the Medicalization of Grief**

The concern sharpens when PGD is situated alongside a related revision: the removal of the bereavement exclusion from the criteria for major depressive disorder. The exclusion had previously cautioned clinicians against diagnosing depression in the immediate aftermath of a death; its removal permits a depressive-episode diagnosis as little as two weeks after a bereavement. Bandini argues that this compression risks a three-part medicalization—overdiagnosis and overtreatment, an expanded pharmaceutical market, and, most consequentially for the present argument, the displacement of traditional and cultural methods of adapting to the loss of a loved one [6].

This last consequence situates PGD within a well-documented sociological process. Conrad's analysis describes the progressive transformation of ordinary human conditions into treatable disorders and the corresponding transfer of authority over them from religious, communal, and familial institutions to medicine [21]. Foucault's account of the clinical gaze traces the deeper history of this transfer, in which the clinic acquires jurisdiction over states of the person previously interpreted within other frameworks of meaning [22]. Grief is a paradigmatic case: a condition once held within ritual, religious observance, and communal mourning is reconstituted as a target of diagnosis and treatment. Crucially, this is not an anti-psychiatric objection imported from outside the field but a caution voiced from within the psychiatric literature itself. Wakefield warned that translating the intuition that grief can sometimes malfunction into formal diagnostic criteria demands the utmost care, since criteria that are too inclusive would mistakenly pathologize large numbers of normally grieving individuals [23].

## **5. The Sociology of a Diagnosis**

### **5.1. Self-Stigma and the Why-Try Effect**

Diagnostic labels do not merely describe; they act upon those they name. Corrigan and colleagues describe the why-try effect, by which individuals internalize public stereotypes about mental illness through a sequence of awareness, agreement, and self-application that progressively erodes self-esteem and self-efficacy [7]. Applied to grief, the mechanism is troubling. A bereaved person who internalizes the designation of disorder may come to read their continuing love and mourning not as a human response to loss but as a symptom of personal incompetence or failure

of functioning. The diagnosis thereby risks producing the very incapacity it purports merely to identify—a self-fulfilling pathologization in which the label, rather than the loss, becomes a source of disability.

## 5.2. Disenfranchised Grief and Cultural Variation

The diagnosis also interacts with the social regulation of mourning. Doka's concept of disenfranchised grief names sorrow that cannot be openly acknowledged, publicly mourned, or socially supported because it violates prevailing norms about who may grieve, for whom, and for how long [24]. A diagnostic criterion that frames extended grief as disordered lends clinical authority to the social expectation of forward movement, converting the mourner's persistence from fidelity into non-compliance and their sustained attachment into a failure to let go. Walter's biographical model points in the opposite direction, describing healthy grief as the construction of a durable biography that integrates the dead into the survivor's ongoing life rather than relinquishing them on schedule [25].

Cross-cultural evidence compounds the problem. Rosenblatt's review of grief across cultures documents that in many societies it is not expected that one will "get over" a loss, and that the work of mourning may be understood as a lifelong process rather than a time-limited task [8]. The temporal expectations encoded in the criterion are, on this evidence, culturally particular rather than universal. The developers of the parallel ICD-11 category were themselves attentive to this concern, arguing that the diagnosis had to be framed for international applicability and clinical utility across settings rather than calibrated to a single cultural baseline [26]. Eisma, reviewing the controversies surrounding PGD in both ICD-11 and DSM-5-TR, cautions that it cannot be assumed that diagnostic criteria developed for North American and European populations will prove valid and accurate in different cultural contexts, and notes that for many people severe and persistent grief may be a natural response rather than a medical disorder at all [27]. Qualitative work on what bereaved people actually experience as good support similarly finds that the most valued responses are sustained social acknowledgment and presence rather than the framing of grief as a condition to be treated [28]. None of this shows that a disorder of grief never exists; it shows that the threshold marking it is far more culturally contingent than a single twelve-month interval can accommodate.

## 6. Ongoing Loss: Where the Criterion Fails Most Acutely

### 6.1. A Note on Scope: Bereavement, Analogy, and Diagnostic Spillover

It must be stated plainly at the outset of this section that, as written, DSM-5-TR prolonged grief disorder is a bereavement diagnosis: its criteria are anchored to the death of a person close to the bereaved and to the interval elapsed since that death [4]. Palliative trajectories, dementia caregiving, and forced displacement are therefore not, strictly speaking, within the diagnosis's formal remit. They enter

the argument in two distinct ways, and the distinction matters. In part they function analogically: they are the contexts that most sharply expose what the criterion assumes, because they are situations of genuine, often profound grief in which there is no death and no terminus from which a twelve-month clock could run, so that the very structure of the criterion has no purchase. But the contexts are also raised because of diagnostic spillover in practice—the well-recognized tendency of a salient diagnostic frame to migrate beyond its formal boundaries. Once “prolonged grief” names a disorder defined by persistence, the disposition to read sustained grief as pathological does not respect the nosological footnote restricting the category to post-death bereavement. Clinicians, families, and patients absorb the frame, and the anticipatory grief of the caregiver or the cultural bereavement of the displaced person is liable to be assessed, informally but consequentially, against the same expectation of resolution. The cases below are thus both analogies that test the criterion’s logic and live instances of the frame’s practical reach.

## 6.2. The Structural Mismatch

In ongoing-loss contexts the mismatch between criterion and condition is structural rather than incidental. The phenomenology is distinctive: such persons must grieve in real time, while the losses are still occurring, lacking the temporal separation that post-death bereavement affords. Mishel’s work on illness uncertainty describes how the absence of a clear trajectory dismantles the cognitive structures that ordinarily give events meaning, so that coherence itself becomes difficult to sustain [29]. Lunney and colleagues’ mapping of functional decline at the end of life shows how trajectories of progressive illness extend without the clear terminus that a discrete death provides [30]. This is not a wound healing along a timeline; it is an ongoing relationship with loss that does not conclude because the condition does not conclude—and against which the question of how many months have elapsed has no purchase.

Ambiguous loss presents the limiting case. Dementia caregivers and the families of missing persons live with a loved one who is simultaneously present and absent, required to mourn and to provide care at once, without the verification and finality that clear death confers. Boss argues that such loss defies resolution by its very structure: with no official confirmation of loss and no rituals of support, there is no closure to be had [31] [32]. Forced displacement produces an ongoing loss of a different structural kind, in which the losses are social, relational, and positional; Bhugra describes the resulting cultural bereavement as living in the past while being excluded from the present [33]. In all these contexts the question “has twelve months elapsed since the death?” is not merely difficult to answer; it is the wrong question, because there is no death from which to count and no terminus toward which grief could resolve. To assess such grief against the criterion—or against the disposition the criterion fosters—is to pathologize a proportionate response to a continuing reality, producing the very disenfranchisement described above [24]. Lindgren and colleagues name the grief correlate of these

indefinitely deferred conditions chronic sorrow: a recurring sadness in a situation that has no predictable end, which does not resolve because the condition generating it does not resolve [34].

### 6.3. Moral Injury among Clinicians

The cost is not borne by patients alone. When institutional frameworks require clinicians to document progress toward a resolution that is structurally unavailable, practitioners are placed in an untenable position: either record a movement that has not occurred, or register as ineffective by the framework's own metrics. Carey and colleagues define moral injury as the inner conflict that follows participation—through action, inaction, or witness—in something that violates one's core moral commitments [35], and subsequent work documents such injury among healthcare workers who repeatedly confront a mismatch between the care they know is needed and the care they are permitted or equipped to provide [36]. For the clinician required to assess proportionate grief as pathological, or to pursue a closure the patient's circumstances cannot yield, this mismatch is precisely the wound the literature describes. A diagnostic framework misapplied thus injures at both ends of the clinical encounter—the patient whose grief is recoded as disorder, and the practitioner compelled to do the recoding.

## 7. The Scope of the Critique: When Diagnosis Is Warranted

### 7.1. The Strongest Case for the Diagnosis

Intellectual honesty requires stating the case for PGD in its strongest form before delimiting the critique. Proponents can point to a genuine and previously underserved clinical population: a minority of bereaved persons whose grief is intense, unremitting, and genuinely disabling, and who were poorly served when no category named their condition or licensed access to targeted care. The validation research reports that the refined criteria identify this group with reasonable specificity and that the associated symptoms predict impairment and poor outcomes distinct from those of depression and anxiety [5]. On this view, the twelve-month threshold is not an arbitrary verdict on normal mourning but a deliberately conservative gate, set late precisely to exclude the ordinary grieving majority, and paired with distress, impairment, and cultural-norm provisos for the same protective purpose. A formal category, proponents argue, does not create suffering; it makes already-existing suffering legible to clinicians, reimbursable by health systems, and answerable by interventions with demonstrated benefit. To withhold the diagnosis on sociological grounds, the argument concludes, is to leave the most severely affected without the recognition and treatment a name makes possible.

This is a serious case, and the present argument concedes its core: a subset of grief is genuinely disabling and warrants structured treatment, and a category that secures access to such treatment does real good. But conceding the clinical need does not dissolve the sociological concern, for the two operate at different levels. The proponent's case is about the well-specified center of the category—the se-

vere, unambiguous presentations for which the criteria were designed. The sociological critique is about the category's edge and its social life: how a salient diagnostic frame, once in circulation, behaves in ordinary clinical and cultural practice well beyond the controlled conditions of a validation study. A criterion can be conservatively specified and still license, through the why-try effect, the disenfranchisement of culturally normative mourning, and diagnostic spillover, the pathologization of proportionate grief at its margins—especially among those whose grief is already least socially sanctioned and in the ongoing-loss contexts the category was never built to address. That a tool performs well at its center is not evidence that it is harmless at its periphery, and it is at the periphery that the social costs are incurred.

## 7.2. The Differential, Not the Calendar

The constructive corollary is that the relevant clinical task is differential rather than categorical. There are presentations that genuinely warrant psychiatric assessment and intervention regardless of how loss is structured: active suicidal ideation, psychotic features, severe comorbid major depression that forecloses any engagement with the loss, and functional incapacitation severe and sustained enough to prevent basic self-care. The presence of these indicators, not the mere passage of twelve months, is what marks the threshold requiring intervention. A criterion anchored to elapsed time rather than to function and impairment inverts this priority, making the calendar the arbiter of pathology. The objection advanced here is therefore not to the existence of a diagnostic category for genuinely disabling grief, but to a temporal criterion that, applied as a universal standard and diffused into the surrounding clinical culture, sweeps proportionate sorrow into the domain of disorder.

## 8. Conclusions

Prolonged grief disorder responds to a real clinical need, and nothing in this article disputes that a minority of bereaved persons require structured care that a formal category can help them access. The argument is narrower and more precise. The twelve-month criterion encodes a teleological model of mourning whose empirical foundations have been substantially undermined; it participates in a broader medicalization of bereavement that carries identifiable costs in self-stigma, disenfranchisement, and the erosion of cultural and ritual practice; and it fails most acutely in the ongoing-loss contexts—progressive illness, dementia caregiving, displacement—where loss has no terminus from which a clock could run. Engaging the diagnosis on its own strongest terms, and granting the genuine safeguard of its distress-and-impairment requirement, does not dissolve these concerns, because they arise at the category's social edge rather than its clinical center.

Read together, the conceptual, sociological, and contextual strands converge on a single conclusion: the persistence of grief is not, in itself, evidence of disorder.

For the person whose loss continues, continued grief is frequently the proportionate form that love takes when the loss does not end. A diagnostic system adequate to human bereavement must be able to make the differential judgment that distinguishes disabling pathology from proportionate sorrow, and must resist the temptation to let the calendar make that judgment in its place. As Eisma observes, for many people severe and persistent grief may be a natural response, and not a medical disorder at all [27]. To recognize this is not to abandon clinical rigor but to practice it more precisely.

## Conflicts of Interest

The author declares no conflicts of interest.

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