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PERSPECTIVES

Diagnosing Prolonged Grief Disorder: Cultural Challenges to the *DSM-5-TR* Criteria

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Abstract

Prolonged grief disorder (PGD) was added to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5-TR*) in 2022. It proposed that after persisting in an acute manner for more than a year, grief becomes pathological. This article explores cultural challenges to the application of the *DSM-5-TR* in diagnosing PGD and discusses culturally sensitive approaches to addressing grief pathology. We have identified three key dimensions that present cultural challenges to the PGD diagnosis: duration of mourning, intensity of emotions, and anomalous cognitions. While the *DSM-5-TR* clarifies that PGD symptoms must exceed contextual norms (Criterion E), here we critically assess the relevance and limitations of PGD from a cultural perspective and discuss the role rituals and traditional healing might play in grief interventions.

Keywords Prolonged grief disorder · Grief pathology · Culture · Grief management practices · Traditional healing

With increased efforts to support the bereaved, there are more grief groups, research initiatives, theories, and interventions than ever before. In the 1990s, acute grief

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symptoms became known as "complicated grief" and in 2013, the American Psychiatric Association (APA) proposed persistent complex bereavement disorder as a formal diagnosis (Nakajima, 2018). In 2018, prolonged grief disorder (PGD) was added to the *International Classification of Diseases* (*ICD-11*) and in 2022, it was added to the *DSM-5-TR*, indicating that grief can, like any disorder or medical condition, reach a pathological state requiring clinical treatment (Hilberdink et al., 2023). Despite there being a common history of how this new psychiatric diagnosis came into existence across both diagnostic systems (Prigerson et al., 2021), their criteria differ enough to allow for significant variation when testing the same population for the prevalence of PGD (Treml et al., 2024). Given these differences, here we focus on understanding the particular challenges faced by the *DSM-5-TR* diagnostic criteria for PGD when applied across cultures.

PGD Classification

While celebrated by many within the medical community, others have argued that such pathologizing highlights how grief is neglected and undervalued in Western industrialized societies, which value control and predictability, beauty and health, and discourage the emotional experience of mourning (Cable, 1998). However, Western societies, including the United States, are not culturally monolithic, as they are made up of different ethnic groups which maintain specific cultural ideas and behaviors toward grief that might contrast with those of the wider mainstream culture. This begs the question: to what extent does the new nosological classification of grief address different cultural beliefs and experiences?

We start by highlighting the role of culture: It mediates and moderates personality outcomes (Oishi et al., 2021) and comprises various and often differing worldviews (Hofstede et al., 2010; Inglehart & Welzel, 2005; Schwartz, 2006). Culture has also been shown to be important in determining personal differences, as is the case in studies on subjective well-being (Suh & Koo, 2008). It also determines many aspects of the grieving process. Evidence suggests that it strongly influences whether and what emotions are encouraged (Nordanger, 2007; Rosenblatt, 2003), the length of time permitted to mourn or perform rituals (Djelantik et al., 2021; Wikan, 1990), and the coping techniques and support systems available.

Intervention and Treatment Considerations

All of these have relevance for the PGD diagnostic criteria. To be clear, cultural differences are of clinical importance not only because they implicate PGD symptomatology, but also because they affect how bereaved individuals from diverse backgrounds might respond to psychological support (Su-Kubricht et al., 2024). It is true that the need to provide practical or emotional assistance for people grieving is not only a Western phenomenon; many cultures associate sustained grief with adverse outcomes (Rosenblatt, 2003); yet grief's expression is not the same everywhere. Since current mental health models are predominantly based on Western research,

norms, and assumptions, and not always appropriate or sensitive to the needs of other cultural groups, we need to recognize these needs and conduct research that identifies culturally relevant symptoms that could be targeted by clinicians (e.g., Stelzer et al., 2020).

The impact of culture on the experience of grief is understudied, probably due to the complexity of cultural variables, such as beliefs and concepts (Rosenblatt, 2008), which are difficult to disentangle. Gaining a better understanding of the variety of grief management practices across cultures not only illuminates our understanding of PGD's cross-cultural applicability but also equips bereavement counselors to serve diverse populations and to consider the benefits of different grief-related traditions. So, the following question is posed: What do we know about grief symptoms and how they are arranged into a nosological classification that may properly address diverse cultural groups? In addition, how does culture shape and limit this classification-based diagnosis?

DSM-5-TR Criteria for Prolonged Grief Disorder

Grief is a normal experience of anguish related to a significant loss, in particular the death of a close person, which may involve distress, separation anxiety, ruminative thinking, and, in severe cases, life-damaging behavior (American Psychological Association, 2018a). However, when we consider pathological grief, we are dealing with more prolonged or intense modes of grief that might encompass both bereavement and mourning. PGD has only recently been labeled within the *DSM*. Historically, bereavement was not a pathological state of its own and first appeared in the *DSM-III* as an exclusion criterion for major depression (Bandini, 2015). The fifth edition of the *DSM* also includes bereavement as an exclusion criterion for major depression, yet it was recognized that, although bereavement and depression are similar, they have unique differences (Fox & Jones, 2013). It was these differences that prompted the development of PGD, which was included in the revised edition.

These relate to a greater external focus in the bereaved while a greater internal, self-referent, and preoccupation in the depressed subjects and to the presence of both positive and negative emotions in the bereaved which becomes more variable and diffuse as time passes, while the depressed experience greater difficulty in expressing positive emotions and have more stable debilitating symptoms (Fox & Jones, 2013). Thus, bereaved individuals may develop a depressive state whose treatment may involve a differential management paradigm in relation to normal grief (Parker, 2013). According to Prigerson et al. (2008), individuals with PGD will be stuck in a chronic state of mourning, experiencing an inability to focus on issues beyond the loss they have suffered. Patients with this disorder can also be at risk of intense distress, poor physical health, and short life expectancy (Prigerson et. al., 2022). This is why PGD is seen as a pathological condition in its own right, whose development has been under consideration for some time. Prolonged or excessive forms of grief have been described as *complicated grief*, *traumatic grief,* or even *pathological grief* (Prigerson et al., 1999, 2008; Shear, 2015; Shear et al., 2013). However, there is a certain vagueness or imprecision in the use of words like *complicated* and

traumatic, and the term *pathological* has a negative connotation (Prigerson et al., 2008). Hence, the creation of the label prolonged grief disorder (PGD) (Table 1).

On the surface, the *DSM-5-TR* diagnosis for PGD appears to be flexible enough to accommodate the largest number of persons with clinically relevant symptoms (i.e., to be as transversal as possible to all people experiencing pathological grief). In addition, Criterion E tells us that PGD symptoms, specifically, the duration and severity of the grief, must exceed expected social, cultural, or religious norms, which emphasizes the role of culture in setting the diagnosis. Beneath the PGD criteria, the *DSM-5-TR* includes "Culture-Related Diagnostic Issues" which elaborates on Criterion E. The manual points out that culture may impact grief responses, including duration and also historical variation; however, it is not clear exactly what this means or how this manifests. The *DSM-5-TR* goes on to say that mourning practices sometimes contribute to the prescription or prohibition of specific grief expressions and that a PGD diagnosis requires symptoms to not be better explained by culturally specific mourning rituals. However, the manual does not specify which symptoms are more prone to cultural variability. Finally, the *DSM-5-TR* states that PGD symptoms must occur to a 'clinically significant degree'; however, given the diversity of grief expressions and differing responses to mental health interventions across cultures, there needs to be further clarity on what might be clinically significant in some cultural contexts. To what extent does this classification system remain resilient in the face of cultural diversity, and does it provide an adequate basis for providers to work with people from a variety of backgrounds?

Cultural Limitations to the *DSM-5-TR* Criteria

Despite a brief recognition of how cultural context implicates PGD symptomatology, the *DSM-5-TR* underemphasizes the difficulty of diagnosing this on a global

Table 1 *DSM-5-TR* diagnostic criteria for PGD

Criteria A	A maladaptive grief reaction diagnosable after a year (for adults) or six months (for children and adolescents) since the death of someone with whom the bereaved had a close relationship
Criteria B	Intense yearning and longing for the deceased and/or preoccupation with thoughts or memories of them must have been experienced to a clinically significant degree almost every day for the past month
Criteria C	At least three of the following symptoms have been present to a clinically significant degree almost every day for the past month: identity disruption, disbelief about the death, avoidance of reminders that the person is dead, intense emotional pain or numbness, social disengagement, lack of purpose, and pervasive loneliness
Criteria D	Clinically significant distress or impairment in social, occupational, or other important areas of functioning
Criteria E	The duration and severity of the grief must clearly exceed expected social, cultural, or religious norms for the individual's culture and context
Criteria F	Symptoms must not be better explained by major depressive disorder, post-traumatic stress disorder, another mental disorder, or be attributable to the physiological effects of a substance or another medical condition

scale. Even within one single country, such as the United States, there are different ethnic groups that will have their own ways of expressing grief (Cable, 1998). More specifically, the following symptoms potentially lack cross-cultural applicability: (A) duration of mourning (persisting for more than a year), (B) maladaptive emotions (intense pain), and (C) anomalous cognitions (hallucinations or visitation dreams).

(A). Length of pathological grief. The *DSM-5-TR* maintains that PGD requires the death of a loved one to have occurred at least 12 months prior for adults and at least 6 months prior for children and adolescents (Criterion A) (*DSM-5-TR*; APA, 2022). However, the duration of mourning varies individually and culturally in accordance with religious and societal norms and expectations, the nature of the relationship with the deceased, or the type of death. In the United States, many employees experiencing a loss receive paid leave for one to two weeks. For individuals who do not have the means to take additional time from work, the window of time allotted by paid leave acts as a designated period within which they must move on. Although an avoidance of death, loss, and grief has been observed in the Western world (Ariès, 1991; Cable, 1998), and employment contracts usually demand that grief is dealt with quickly, studies of various groups within the United States show a different landscape. For example, Jewish Usonians may experience longer periods of mourning as their tradition prescribes fixed mourning rituals for the first week, month, and year after the loss of a loved one (Silverman, 2021). In turn, Mexican Usonians may experience the loss of a loved one as a lifelong and ever-present process (Doran & Hansen, 2006). Additionally, in many non-Western cultures, mourning practices or rituals tend to exceed a year. In Bali, bereaved individuals perform numerous rituals to care for the deceased several years following the death (Djelantik et al., 2021). Granted, grief is not necessarily acute all these years; however, it is still significant that some cultures create time to grieve even years after a death. Furthermore, although the *DSM-5-TR* maintains that difficulty reintegrating into society could be a symptom of PGD, studies suggest that for some groups, such as the Zulu, prematurely integrating into social activities (especially for widows) would be seen as inappropriate or disrespectful rather than healthy progress (Rosenblatt & Nkosi, 2007). Taking these cases into account, it is reasonable to say that the length of mourning may not be reducible to a generalizable time frame. While longer periods of mourning do not necessarily mean the presence of symptoms associated with PGD, it is worth recognizing that many non-Western cultures encourage loss-related activities for a significant amount of time, likely impacting grief trajectory.

(B). Maladaptive emotion. PGD symptoms include feeling intense yearning/longing for the deceased person to a clinically significant degree (Criterion B), having difficulties integrating into one's relationships and activities, and experiencing identity disruption, numbness, and intense emotional pain to a clinically significant degree (symptoms listed within Criterion C) (*DSM-5-TR*; APA, 2022). However, social determinants cause variation in emotional responses to grief (Lofland, 1985; Rosenblatt, 1988) and grief processes (Jakoby, 2012; Neimeyer et al., 2014). According to various studies, grief can be seen as a social emotion (Averill & Nunley, 1988; Jakoby, 2012) or an experience in which the associated emotions can be framed in a socio-functional way (Bonanno, 2001) as, for example, the specific

vocabulary for grief developed across cultures and the reasons for promoting or discouraging particular emotions (Aksoz-Efe et al., 2018; Nordanger, 2007). Although some common responses to loss have been identified across cultures (denial, despair, guilt, anger, low self-esteem), these are emphasized or de-emphasized differently (Rosenblatt, 2003). For example, Xiu and colleagues identified more preoccupation and rumination among Swiss participants and more somatic symptoms and functional impairment among Chinese participants (Xiu et al., 2016). The actual length of time permitted to express a particular emotion is context-dependent too. In some parts of Ethiopia, religious leaders have discouraged the bereaved from persistent sadness, with the belief that mourners would only be perpetuating grief and that they might become susceptible to illness such as blindness (Nordanger, 2007). In this case, avoidance of reminders of the deceased would not be seen as maladaptive but rather encouraged in an effort to reduce intense grief. In contrast, some cultures endorse feeling and displaying intense emotions. For example, in the Peranakan community (a Chinese culture within Malaysia and Singapore), it is not uncommon for professional mourners to be hired to cry during funerals (Sankar et al., 2016). In other cultures, rather than sadness, anger is a predominant emotion during bereavement (Rosenblatt, 2003).

Other comparative studies shed light on emotional differences in the grieving process. In a comparison of grief among students from the United States and Spain, Catlin (1993) found that grieving Usonians had both low self-esteem and low liking and trust in others, while the Spanish participants showed low self-esteem but high liking and trust in others. Another study that compared Usonian and Chinese participants found that Chinese participants had a more acute grief response pattern in the initial months of mourning and then a greater recovery than Usonians (Bonanno et al., 2005). Additionally, while continuing bonds with the deceased has been associated with long-term adjustment for Chinese individuals, it has been associated with poor adjustment among Usonians (Lalande & Bonanno, 2006). It can therefore be said that there are cultural differences between Usonians and others from different countries when it comes to the emotional experience of grief. So, could there be any differences in grief-related emotions among Usonians depending on their ethnic background? It seems so. In a study by Oltjenburns (1998) that compared Mexican Usonians with Anglo-Usonians in their grief experience, it was found that the Mexican Usonian participants had a greater loss of control and somatization in their response to grief. While we clearly need more studies addressing such grief differences within the Usonian population, the existing research suggests that these are not trivial and that they must be given due consideration within the *DSM* PGD criteria. Future studies might also address cross-cultural grief involving 'clinically significant' symptoms which extend beyond early, acute stages of grief, and that persist for over 6 months or a year.

(C). Anomalous cognitions. Although not included in the main PGD criteria, beneath 'Associated Features' of the disorder, the *DSM-5-TR* indicates that hallucinations, although sometimes occurring during normal grief, may be more frequent for individuals with PGD and that hallucinations during PGD might be related to disruption of social identity and purpose (symptoms listed in PGD criteria) (*DSM-5-TR*; APA, 2022). However, having 'after-death communications', or ACDs, where

the bereaved has a sensory experience involving the deceased is common across cultures, age, and religious affiliation and may be adaptive for the bereaved (Elsaesser et al., 2021; Kamp et al., 2020). Elsaesser and colleagues (2021) found that such experiences can provide a deep sense of meaning, comfort, and emotional healing. Across three language groups (English, French, and Spanish), the majority of participants reported that the sensory experiences were significant to their grieving process and through them participants even indicated they had become less fearful of death (Elsaesser et al., 2021). In the Yanomami culture, from the Amazon, dreams with deceased relatives are a common occurrence, which are interpreted as literal visitations from the dead who wish for the living to join them in that realm (to make matters more complicated, the dead think of themselves as alive but separated from their family members). These visitations are not culturally perceived as abnormal, although those who dream of the dead relatives are taught to resist their call to join them (Limulja, 2022).

However, within Western cultures, it is common to view such experiences as an indication of unprocessed trauma or pathology, even signaling to a counselor the progress of a client's grief journey (Garfield, 2001; Hinton et al., 2013; Roe, 2020). The *DSM-5-TR* also cautions that the importance of dreams in some cultures could lead to extreme distress (if the dream reveals something negative about the deceased). The Western perspective is quick to recognize such discomfort as a clinical impairment needing intervention, rather than as a natural part of a cultural or religious identity. Particularly in this context, the concept that symptoms must cause "notable distress or impairment" (Criterion D) poses challenges when considering how, within some cultures and in accordance with some spiritual beliefs, distress arising from practices such as interpreting dream visitations is not necessarily discouraged or something to try to escape from, but rather accepted and seen as necessary for it allows the bereaved to take steps to ensure a positive afterlife for the deceased (Hinton et al., 2013). For example, within Cambodian culture, the bereaved might learn that their loved ones' spiritual status is in jeopardy during a dream visitation. The distress caused by the visitation is necessary because it prompts the bereaved to perform rituals to improve the spiritual status of the deceased. In fact, Hinton et al. (2013) report that after completing such rituals, the bereaved experience a decrease in distressing dreams of the dead and grief symptoms. It is relevant to note the key difference between distress and impairment: within some traditions, distress may not warrant clinical attention but rather be interpreted as a valued function of a culture, important for social relatedness and even survival. On the other hand, it is likely that a grief experience which, for example, involves being unable to sleep for one week or more would be understood as an impairment cross-culturally.

Therapeutic Considerations

Considering that a diagnosis of PGD will be relevant in the decision to implement a bereavement intervention, the cultural limitations and lack of cultural sensitivity take on particular importance. Current grief models are largely based on research within a Western context, and culture-specific interventions are rare. Therapeutic

approaches typically use grief management frameworks, such as Stroebe and Schut's (1999) dual process model (DPM) where successful grieving includes both confrontation of loss through loss-focused activities (e.g., thinking about the death, looking at photos) and avoidance of loss through restoration-focused activities (e.g., taking on the deceased's responsibilities). Although there are various theories, models, and stages associated with grief, their underlying mechanisms (attachment, balance, restoration, etc.) usually assume Western values and beliefs.

In 1996, Klass and colleagues (1996) introduced the concept of 'continuing bonds,' challenging the Freudian idea that severing ties with the deceased was required for successful post-loss adaptation (Klass, Silverman, & Nickman, 1996). Although bereavement models in the West continue to emphasize detachment, this may not be the best approach for everyone, especially for those from non-Western cultures (Elsaesser, et al., 2021; Roe, 2020; Shapiro, 1995). For example, in a traditional Japanese home where remembrance of ancestors is particularly valued, a family may create a shrine where they communicate with their loved one (Cox & Thompson, 2022). Sensory experiences with the deceased (such as auditory or visual hallucinations, visions, or dreams) are additional ways to continue bonds with them. We recommend that bereavement professionals explore the adaptive nature of these events.

Despite a lack of consistent cross-cultural studies on this subject, there are qualitative and anecdotal data suggesting that the use of rituals and traditional healing practices has therapeutic functions (Djelantik et al., 2021; Kokou-Kpolou et al., 2017). The *DSM-5-TR* points out that when individuals do not have the ability to carry out funeral rituals, they might be more susceptible to experiencing PGD symptoms (*DSM-5-TR*; APA, 2022). It is thus important to consider how these might be implemented in addition to or in lieu of a Western PGD intervention.

Rituals surrounding death are commonly found across cultures, and they aim to facilitate mourning by providing a way to honor the dead, ensure a positive afterlife, and maintain a relationship with the deceased. For instance, in Turkey, closing the deceased's eyes and attending to arrangements in the room during the wake allow the bereaved to continue to care for their loved one (Aksoz-Efe et al., 2018). In Cambodia, mourners chant through the night, give gifts to the deceased, and cleanse the ashes after cremation (Hinton et al., 2013). Especially in the case of a sudden death, rituals might help the bereaved to manage their shock (Kokou-Kpolou et al., 2017). Within the United States, culture-specific rituals might also be relevant to the grieving process — for example, Usonian Jews prescribe mourning rituals and prohibitions based on respect for the deceased and to comfort the bereaved (Silverman, 2021). These rituals are prescribed for the first week, month, and year after the loss. Mourning rituals are also important to Mexican Usonians and often involve visits to the cemetery (Doran & Hansen, 2006). Such practices can afford closure and give mourners confirmation that they are appropriately dealing with the loss.

There is some evidence that rituals such as these may be a protective factor against PGD. One study explored grief reactions among inhabitants of Bali who had lost someone in a traffic accident and found significantly lower rates of PGD compared to world-wide PGD prevalence after unnatural loss (Djelantik et al., 2021). The majority reported participating in rituals that involved caring for the deceased

by looking after their spiritual transition from life to death. Along with a sense of caring for their loved ones, the bereaved also benefited from the support found in performing rituals together. Importantly, participants did not report significant levels of isolation, diminished sense of self, suicidal ideation, or depression — symptoms that have been associated with PGD and PTSD in Western populations. Similarly, another study found that bereaved Togolese immigrants who participated in mourning rituals experienced less guilt and despondency (Kokou-Kpolou et al., 2017).

Future studies should also explore the potential role of traditional healing in supporting individuals experiencing PGD symptoms. Traditional healing, an approach to healthcare rooted in indigenous religions, relies on natural and spiritual practices rather than conventional medical treatment (Gureje et al., 2015). Research in Ghana and Nigeria provides evidence that, at least for some psychological concerns, integrating traditional and faith healing (TFH) practices into healthcare systems is beneficial (Gureje et al., 2020).

Although the use of TFH in the context of PGD is less understood, in many small-scale societies, ritual specialists play an important role in guiding the mourning period (Rosenblatt, 2015). There are examples from Malaysia, India, Nigeria, South Africa, and the United Arab Emirates, where mental health patients consult with a traditional healing practitioner as they determine their need for conventional care (Gureje et al., 2015). In sub-Saharan African countries, TFH has been utilized to supplement formal health care professionals in supporting individuals with psychosis (Gureje et al., 2020). This has allowed poorly resourced regions to offer care for more people and to do so in a way that is conducive to cultural expectations and norms.

Given that traditional healing typically operates on some form of spiritual belief, another benefit of such an approach could be that expectations tied to these beliefs influence positive outcomes. In Puerto Rico, for instance, compared to patients of conventional mental health services, patients of traditional healers reported better psychiatric outcomes (Koss, 1987). While the conventional therapists were better at addressing maladaptive thinking, the TFHs were more successful in the treatment of behavioral symptoms, such as aggression, psychophysiological responses (e.g., excessive crying), and stress-related complaints. Given that PGD is categorized as a trauma-and stressor-related disorder, it is worthwhile exploring to what extent these traditional healing practices, by tapping into the individuals' spiritual belief system, might offer an added or alternative route to treating PGD. Needless to say, future studies with careful monitoring are required to assess how effective TFH might be across various cultural contexts in addressing grief pathology; an added benefit of such integration would be the reduction in the stigmatization associated with mental health care.

Conclusion

The addition of PGD to the *DSM-5-TR* indicates that at a certain point, grief becomes a medical condition, just as other diagnoses are given in the presence of a group of abnormal behaviors or symptoms. As a physical and emotional

response to pain, grief is a healing process but may be prolonged or so acute that an individual is unable to resume previous functioning. In some circumstances, such as experiencing a traumatic death, individuals are more likely to have extreme grief reactions and impairment, necessitating clinical attention and support across cultures (Djelantik et al., 2020). However, whether grief pathology according to the *DSM-5-TR* can more generally be extended cross-culturally requires further exploration.

It is proposed here that the *DSM* should be more explicit about the cultural limitations of PGD than what is currently stated in Criterion E (symptoms should exceed social, cultural, or religious norms). This is, in our view, a criterion that would benefit from more fine-grained contextualization. Further research might target specific PGD symptoms listed in the *DSM-5-TR* across cultures (e.g., identity disruption, intense emotional pain, and difficulties reintegrating into society), to better discern the impact of culture on PGD symptoms and in order to gather new data to inform future adjustments to the PGD criteria. Far from advocating a differentiated treatment of PGD for each culture, we believe that a future version of the PGD criteria should emphasize cross-cultural variance on 1) time of bereavement; 2) extent of maladaptive emotional reactions; and 3) cognitive responses. Clinicians should be particularly attentive to these criteria and analyze them according to a) the cultural attitude toward death and b) grief-related attitudes and expectations, including adherence to community and religious support.

Finally, we suggest that providers directly assess their patients' cultural views on grief. This could be done with the development of a semi-structured interview or a checklist that would allow discernment of culturally differentiated attitudes toward death and grief. One attempt to understand cultural variations has already been trialed with the *ICD-11*, with German speakers and Chinese and Swiss migrants (Killikelly & Maercker, 2023). Even within the United States' culturally diverse context, one could perceive a benefit in such a culturally sensitive tool, considering its diverse ethnic groups (e.g., Native Usonians, African Usonians, Asian Usonians, Jewish Usonians, Latino Usonians, etc.). Our hope is that a more culturally sensitive approach to prolonged grief and consideration of traditional or indigenous coping techniques will help in the development of more effective treatments.

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Data Availability There is no original data from the current study.

Declarations

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethical Approval The article draws upon existing research and literature and did not involve participants; ethical approval was not required.

Consent to Participate The article draws upon existing research and literature and did not include recruitment of participants; informed consent was not of relevance.

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