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Echoes of the Rupture: Anguish in Prolonged Grief Disorder

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Abstract

Background: Prolonged Grief Disorder (PGD) is a newly recognized diagnostic category in the ICD-11 and DSM-5-TR, defined by persistent yearning and preoccupation with the deceased. Despite established diagnostic criteria, there remains a gap in capturing the lived experience of patients, who often report a profound suffering that exceeds standard symptom checklists. This profound suffering aligns with the phenomenological concept of "anguish," an affective state where existence feels threatened, constricted, and stripped of its future horizons.

Methods: This article utilizes a conceptual and historical framework to argue that anguish deserves standing as a core affective construct in PGD. The paper synthesizes existential philosophy and phenomenological with contemporary clinical, epidemiological, and neurobiological research concerning severe grief.

Results: The phenomenology of anguish in PGD is organized across four distinct dimensions: embodied anguish characterized by somatic constriction and chest tightness, temporal rupture involving deep desynchronization where time feels frozen, self-world disturbance marked by a breakdown of identity and affective trust, and diffuse existential insecurity. Neurobiologically, this phenomenological state corresponds to alterations in the brain's reward and pain circuits hypothalamic-pituitary-adrenal (HPA) axis dysregulation and autonomic disarray. While anguish can operate as a transdiagnostic affective process, its presentation in PGD is uniquely characterized by the paradox of the deceased's "presence in absence".

Conclusions: Standard assessment tools operationalize diagnostic criteria but do not directly assess the distinct existential and somatic features of anguish. Utilizing a phenomenology-informed case formulation allows clinicians to capture the depth of this self-world disturbance. To effectively treat PGD, evidence-based therapies must integrate narrative, temporal, and body-oriented interventions to address the profound ruptures in the patient's relational and embodied existence, ultimately facilitating a more comprehensive healing process.

Keywords

Anguish, Prolonged Grief Disorder, Phenomenology, Transdiagnostics, Vital Mood

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Introduction

Prolonged Grief Disorder: Definitions and Core Criteria

With the editions of both the ICD-11 (1) and DSM-5-TR (2), Prolonged Grief Disorder has been added as a new diagnostic category, an important step forward in how we understand grief psychopathology. PGD is quite distinct in nature; it is no longer a matter of adaptation but rather a chronic condition that permeates day-to-day living. What defines the disorder are two things: a pervasive yearning for the one who has passed and a persistent preoccupation with memories of them. (3,4)

The DSM-5-TR requires one or both core symptoms (intense longing/yearning or preoccupation) and at least three accessory symptoms (e.g., identity disruption, marked sense of disbelief about the death, avoidance of reminders, intense emotional pain, difficulty reintegrating into life, emotional numbness, feelings that life is meaningless, and intense loneliness) resulting in significant functional impairment for adult diagnosis no earlier than 12 months after the death (2,3,5). Furthermore, ICD-11 requires the core separation distress, accompanied by one broader accessory symptom (e.g., sadness, guilt, anger, denial, blame, difficulty accepting the death, felt loss of part of oneself, inability to experience positive mood, emotional numbness, and social withdrawal) with functional impairment persisting for at least six months beyond the loss and clearly exceeding cultural norms (1,3,5)

This differentiation in the diagnostic criteria is reflected in the epidemiological data. Studies, using validated instruments capturing both criteria sets, demonstrate that PGD (DSM-5-TR) prevalence among bereaved individuals is estimated at approximately 4.7%, while PGD (ICD-11) prevalence reaches approximately 5.4% (under minimum criteria) and up to 6.8%, when the time-since-loss criterion is applied more liberally. Broader clinical estimates set the prevalence of clinically significant prolonged grief at 7–10% of bereaved individuals across diverse populations. Risk factors include the nature of the loss (sudden, violent, or traumatic deaths), the closeness of the relationship (loss of a child or romantic partner carrying the highest risk), and pre-existing vulnerabilities in attachment and identity. (2,6)

The clinical significance of PGD lies in its associations with severe comorbidity and functional deterioration. PGD has been associated with suicidality and adverse physical-health indicators. Even when co-occurring depression, posttraumatic stress disorder, and anxiety disorders are carefully controlled, the functional burden of PGD retains its distinctiveness (5, 7). These findings point toward a psychopathological core not fully captured by any single existing category.

Rationale for Focusing on Anguish as a Distinct Construct in PGD

Despite the research progress in PGD, a persistent gap remains between the diagnostic criteria and the lived experience. Clinicians and researchers consistently encounter presentations in which the suffering seems to exceed the symptom checklists; an enveloping quality of distress that operates not only at the level of emotions or cognitions but at the level of the person's entire relationship to time, body, and world. (8) Patients describe not a mere sadness or anxiety, but something closer to what the phenomenological tradition calls anguish (an affective state in which existence itself appears threatened, constricted, and stripped of its forward-facing horizons).

This article argues that anguish deserves conceptual standing as a core affective construct in PGD. It is neither a synonym for severe anxiety or intense sadness, nor a vague label for suffering that exceeds measurement. Rather, anguish names a philosophically and clinically specifiable affective mode with distinct phenomenological features. Attending to anguish can enrich clinical formulation, sharpen research targets for measurement and mechanism, and provide therapists with a more adequate account of what patients with PGD are experiencing.

History and Clinical Use of Anguish

The word anguish originates from Old French anguisse and from the Latin angustia, meaning narrowness or tightness. It stems from the Proto-Indo-European angh-, signifying painful constriction. This etymology is not only philological, but it also encodes the somatic phenomenology of the experience. Romans used angor and the verb angere to denote the crushing and strangling pressure of the chest. Furthermore, the German Angst and the Greek verb ἄγχω share the same root of painful narrowness. (9,10) The affinity between this sense of constriction and mental suffering was not metaphorical, but phenomenologically descriptive. Anguish is the experience of being squeezed, compressed, unable to breathe freely, caught in a grip from which there is no immediate exit. (11)

Within clinical psychiatry, the term has occupied an uneasy and often subterranean position. European psychiatry long distinguished angustia or Angst from mere unease or worry, reserving it for states of pervasive and intolerable suffering with somatic depth (11). Karl Jaspers attended carefully to the phenomenology of vital feelings (Vitalgefühle), recognizing that states such as anxiety and anguish could alter the fundamental tone of a person's entire embodied existence rather than simply comprising discrete emotional episodes. (12) For Jaspers, phenomenology in psychiatry was not the application of a philosophical system but a rigorous empirical method for recovering the patient's first-person experience from behind theoretical preconceptions (13). Moreover, the careful phenomenological description of what patients call anguish was a prerequisite for genuine clinical understanding.

The subsequent fate of the concept in Anglophone psychiatry was one of progressive narrowing. Aubrey Lewis's (14) influential definition constrained anxiety to a future-oriented state of fearful anticipation, and psychopharmacological taxonomy further compressed the phenomenological landscape into operationally defined symptom clusters. Anguish did not fit into either the anxiety disorders or the depressive spectrum, it remained a residual term used in clinical narrative rather than diagnostic coding.

Conceptual Foundations of Anguish

Existential and Phenomenological Perspectives

The most thorough philosophical accounts of anguish in the existentialists' tradition, is a concept with ontological weight rather than a mere clinical observation. Kierkegaard is a case in point. In The Concept of Anxiety (15) he speaks of Angst (dread or anxiety) not as a reaction to some specific danger but as the vertigo of being free. Take the example of a man on a cliff: he may well fear the fall, but anguish is the dizzying knowledge that he has the option to take it. There is no sure footing for the self's actions and determinations; freedom holds out the most annihilating of possibilities. For Kierkegaard, then, anguish is the mood of what is possible, not what is actual. It comes on when the self is faced with the abyss of its own finitude and the stark openness of its existence in the face of God and death. As Ormeny notes, this has a temporal quality to it, an orientation to an open present full of undetermined potential rather than to the past or future (9).

Sartre extends Kierkegaard's analysis in Being and Nothingness (16), locating anguish in the odd way human consciousness exists as néant, or nothingness. Consciousness is never quite itself, always in question and projecting into what it has yet to become. Anguish is the feeling of that fact, the realization that there is no fixed essence or identity to hold you steady against the vertigo of responsibility. Sartre is careful to put a line between anguish and fear: the latter is an outward thing, aimed at threats in the world, whereas the former is turned inward on the very make-up of one's freedom. You can run from it in bad faith, putting on the act of being a determined object like any other, but the anguish lingers as the truth of your consciousness.

Furthermore, Heidegger's approach in Being and Time (17), adds a dimension useful for making sense of PGD. His notion of Angst reveals Dasein's thrownness and its Being-toward-death. When anxiety sets in, the world's easy familiarity is gone and you are left with Unheimlichkeit (uncanniness). All the usual scaffolding of meaning gives way; the world is stripped of the reassurance of ordinary engagement and becomes strange and threatening without any particular object to point to. Brencio would say this is a phenomenological description of affective trust breaking down, of the prereflective confidence that one is at home in the world and part of its fabric (18). Anguish is what you are left with when that trust is gone.

These are the tools that phenomenological psychiatry has put to use in the clinic. Following the German tradition of Erwin Straus and the Heidelberg school, they have developed the idea of a vital mood (Vitalstimmung). This is not a discrete emotion with an object but a pervasive alteration of the whole bodily and experiential field. (19)A vital mood does not just alter your feelings about one thing or another; it changes how the body and the world come across to you. In this light, anguish is a 'Stimmung', an attunement that tints the entire lifeworld and makes social and temporal projection feel fundamentally different from the norm. Messas and colleagues (20) have taken this further in their work on emergency psychiatry, demonstrating that we should see such extreme states as a modification of the patient's lived embodiment and space, not as symptoms in isolation.

Prolonged Grief Disorder as a Clinical Laboratory of Anguish

Diagnostic Status and Epidemiology of PGD

Pathological manifestations of grief were kept out of diagnostic categories. A body of work has made a compelling case that some of the bereaved develop a syndrome all its own, one with a unique profile of dysfunction, comorbidity and treatment response that sets it apart from major depressive disorder, PTSD or generalized anxiety. (1) That evidence has paved the way for PGD to be put on the map as a bona fide diagnostic entity. After being given provisional status as Persistent Complex Bereavement Disorder in DSM-5 (21), it was formally adopted by the ICD-11 and the DSM-5-TR.

In population-based research, most highlighted symptoms are intrusive thoughts or images related to the deceased (approximately 30.7%), longing or yearning for the person who died (approximately 23.4%), difficulty accepting the loss (approximately 23.3%), and feeling stunned, shocked, or dazed by the death (approximately 19.6%). Functional impairment severe enough to meet diagnostic thresholds is reported by approximately 8.9% of bereaved individuals in such samples. (4)

Risk factors for PGD constitute the loss of a child or partner, after sudden or violent deaths, individuals with history of insecure attachment, prior psychiatric disorder, or limited social support. (22,23) The disorder's distinctive quality lies not only in its temporal prolongation but in its qualitative texture: where most bereaved individuals gradually accommodate to loss, reorganizing their relational and temporal horizons, those with PGD remain caught in a state that resists adaptation, as though the normal mechanisms of experiential processing and meaning-making have been interrupted or disabled. (24)

Clinical Phenomenology of Prolonged Grief

Clinical and phenomenological accounts of PGD consistently describe a quality of suffering that exceeds what formal criteria can convey. Patients use language that points toward anguish in the philosophically rich sense articulated above: they speak of inhabiting two worlds simultaneously (one in which the deceased still exists and one in which the loss has occurred) without being able fully to occupy or leave either. This "presence in absence" generates an enduring ambiguity that forecloses the kind of definitive orientation that would allow temporal movement and adaptation. (25)

According to the phenomenological analysis put forward by Thomas Fuchs (25), there is a basic opposition can be described. On one side the bereaved have presentifying tendencies that hold on to the deceased in terms of memory, sensation and what one expects from a relationship; on the other are de-presentifying ones that make the fact of their absence plain. In the course of normal grief one comes to terms with this conflict, if not completely then well enough, as the beloved is slowly made into an internalized presence rather

than a living partner, something you can move on with without your existence being upended. But in PGD the process is stymied. The individual is left in some kind of experiential limbo between being there and not and cannot go through the mourning required to keep time moving. Hughes would call it a deep temporal desynchronization. (26) It is a breaking of the rhythm of one's lived time where the past, present and future do not mesh as they should but are fractured, so the bereaved is left with no coherent story to their life.

A phenomenological survey of grief experiences further substantiates this picture. First-person accounts of bereavement reveal not only sadness but a distinctive restructuring of the way the world appears: alterations in the sense of belonging, of social connection, of the reliability of practical projects, and of the body's comfort with its environment. (27) These alterations are not merely cognitive beliefs or emotional reactions but changes in the fundamental pre-reflective structure of experience. When these alterations become chronic and self-reinforcing, as in PGD, the resulting state is closer to what the philosophical tradition calls anguish than to what symptom checklists capture under headings like "intense longing" or "difficulty reintegrating". (28)

Phenomenology of Anguish in Prolonged Grief Disorder

Embodied Anguish

Anguish, as historically described and phenomenologically analyzed, is never purely mental: it is always also a bodily state. The etymological root of the term itself points to the physical dimension, and clinical descriptions confirm it. Patients with PGD frequently report somatic experiences including chest tightness or pressure, a sensation described as a "hole" or cavity in the chest or abdomen, difficulty breathing, agitation, and a pervasive heaviness that seems to make the body itself an obstacle. These are not mere metaphors; they are genuine modifications of bodily self-experience that shape how the world appears and how engagement with it feels. (29,30)

Fuchs's concept of the "bodily resonance" of emotions illuminates this dimension. (25) In grief, the body does not simply register an inner psychological state but resonates with the altered relational and temporal situation of the bereaved person: it is the medium through which the loss is felt as a disruption of the entire spectrum of lived experience. The chest tightness of anguish is the somatic inscription of a world felt as constricted, threatening, and suffocating. Recovery of the body in grief research has increasingly emphasized that bereavement is not only a psychological but a somatic and proprioceptive event: the loss of an attachment figure withdraws the physiological co-regulation that the relationship provided, leaving the body in a state of dysregulation that expresses itself as physical symptoms alongside the emotional ones. (29,30)

In PGD specifically, this embodied anguish tends to be chronic and intractable rather than episodic. Whereas in ordinary grief, somatic distress typically diminishes as accommodation proceeds, in PGD the bodily experience of constriction may persist for years, forming an affective background that makes ordinary physical comfort feel inaccessible. Patients may describe feeling that their body no longer belongs to them, or that it has been permanently altered by the loss. This embodied alienation is one of the features that distinguishes anguished PGD from the predominantly cognitive or motivational features of depression, even when the two conditions co-occur. (29, 31)

Temporal Rupture and Stasis

One of the most clinically and philosophically striking features of PGD is its distinctive disruption of temporal experience. In phenomenological analyses of grief, time does not simply pass more slowly or painfully after a significant loss; it undergoes a more radical restructuring in which the basic flow and integration of past, present, and future is disturbed. For many bereaved individuals, the moment of the loss becomes a kind of temporal anchor that both organizes subsequent experience and prevents it from moving freely toward a new future. (32)

Hughes describes this in terms of temporal desynchronization: the internal rhythm of lived time falls out of phase after bereavement, particularly in complicated or prolonged grief. (26) Time may feel frozen at the moment of loss, repeating the same unbearable instant without progression, or it may feel empty. The bereaved person experiences themselves as left behind by time rather than moving through it which leads in a temporal isolation in which the rest of the world has become estranged. (32)

Fuchs links this temporal stasis to the interruptive logic of loss itself. The deceased had been a constitutive element of the bereaved person's temporal horizon (25). When the other dies, not only the present relational world but the anticipated future is retroactively voided: the bereaved person finds themselves unable to project forward into a future that is no longer the future they had expected. In PGD, this inability becomes entrenched: the person remains experientially oriented toward the lost relationship, unable to generate new temporal horizons that do not include the deceased. (32) Anguish is the affective signature of this temporal blockage , the mood of a time that will not move, of a self suspended between an irretrievable past and a future that cannot yet be imagined.

Self–World Disturbance

A third dimension of anguish in PGD concerns the disruption of the fundamental relationship between self and world. Under ordinary conditions, the self is not simply a subject enclosed within itself but is constitutively embedded in a relational, cultural, and temporal world, which provides the background conditions of intelligibility, belonging, and orientation that make experience possible. (28) This embedding is normally taken for granted: the world appears as familiar, inhabitable, and reliably continuous with one's own projects and identity. The bereaved individual in PGD has lost this taken-for-granted background in a particularly radical way. (33)

Research on identity disruption in complicated grief reveals

that the loss of a central attachment figure is simultaneously a loss of self-definition: the bereaved person loses not only the other but the aspects of their own identity that were constituted in and through the relationship. (31) Studies show that bereaved individuals with complicated or prolonged grief display significantly lower self-clarity and greater identity confusion than those whose grief proceeds without clinical complication, and that this reduced self-clarity is independently predictive of depressive and functional impairment. The sense of having "lost a part of oneself" (listed as a criterion in DSM-5-TR) is not merely a metaphor but a phenomenologically accurate description of what occurs when an identity-constituting relational bond is severed without the possibility of experiential reorganization. (33,34)

In PGD, this self–world disturbance takes on the quality of what Fuchs described as affective trust. When a central attachment figure dies, this affective trust does not simply diminish; in PGD it may be fundamentally undermined, leaving the person in a state of ongoing existential insecurity in which the world as a whole has become threatening, unreliable, and alien. Patients describe alienation not merely from specific places or activities but from the ordinary sense of being at home in existence. This alienation cannot be addressed at the level of individual cognitions because it is not itself a cognition: it is a modification of the pre-reflective background against which all cognitions, perceptions, and actions take place. (25)

Diffuse Threat and Existential Insecurity

The fourth and in some ways most philosophically distinctive dimension of anguish in PGD is its character as a diffuse, objectless threat. This distinguishes anguished PGD from fear of concrete consequences and from the future-oriented, anticipatory character of anxiety as conventionally described. (14,17) The bereaved person does not merely worry that they will be unable to cope or fear a specific future outcome; they inhabit a sense that something has already irreparably ruptured in the structure of their existence, and that no action or realization can fully address this rupture (35).

The deceased, in this context, is not simply the object of anguish but the marker of a deeper ontological rupture. The loss reveals, with an immediacy that cannot be argued away, the radical contingency and vulnerability of all that one had taken as stable: the relationships that constituted one's identity, the future one had assumed, the world that had seemed reliably continuous with one's own existence. Anguish in PGD is the affective tone of this revelation. The diffuse, global quality of this threat is central to its phenomenology: it does not have the specific object of fear or even the anticipatory quality of anxiety, but rather the pervasive, atmospheric quality of a world that has become fundamentally unsafe, strange, and menacing in a way that cannot be simply identified or neutralized. (30,36)

Ratcliffe has emphasized that first-person accounts of bereavement sometimes describe experiences that resemble the background sense of safety and orientation being removed (35). This is particularly marked in PGD: the person does not simply lack specific reasons for hope but has lost access to the background sense that hope is even possible. Existential insecurity of this kind is not merely a symptom among others but a modification of the entire experiential field, making it the appropriate focus of clinical attention in its own right.

Neurobiological and Psychophysiological Correlates of Anguished Grief

Pain, Reward, and Attachment Circuits

One of the most significant findings in the neurobiology of PGD concerns the involvement of the neural reward system in the maintenance of grief symptoms. Kakarala et al. (6) found converging evidence for differential activation of several reward-related brain regions in those with prolonged as compared to normative grief. The areas for which the strongest evidence was found include the nucleus accumbens (NAc) and basal ganglia broadly, the amygdala, the insula, the cingulate cortex, and the orbitofrontal cortex.

A prominent and often-cited finding, NAc activation in response to grief-related stimuli, suggests that the longing may operate through mechanisms normally associated with reward and appetitive motivation. The bereaved person continues to experience cue-triggered responses to reminders of the deceased even as the deceased remains unavailable, creating an a craving-like process and deprivation. (37,38) O'Connor et al.'s (39) original observation that those with complicated grief showed heightened NAc activation when viewing grief-related stimuli, in contrast to non-disordered bereaved individuals for whom this activation diminished over time, was subsequently supported by evidence of approach-avoidance conflicts, attentional biases toward loss-related cues, and altered oxytocin signaling. All of these findings are consistent with conceptualizing the disorder as involving a persistent dysregulation of the attachment-reward system.

This neurobiological picture is compatible with the phenomenological account, but it should not be read as a direct reduction of anguish to circuit activity. Persistent reward-circuit responsiveness to reminders of the deceased (6) may help explain why some bereaved individuals remain motivationally oriented toward a relationship that can no longer be enacted. In this sense, reward-system findings may provide one mechanistic correlate of the phenomenological tension of presence in absence. (25)

Bryant et al. (40) compared PGD, PTSD, MDD, and bereaved controls and further documented that PGD is associated with greater activation of the pregenual anterior cingulate cortex and bilateral insula (regions involved in the processing of social and physical pain) as well as the caudate and putamen, which are implicated in reward anticipation and habit formation. Compared to PTSD and MDD specifically, PGD showed greater activation of the medial orbitofrontal cortex during processing of sad faces (a region involved in the evaluation of emotional salience and reward value) reinforcing the picture of a distinctively grief-specific pattern of brain activity. These findings converge with contemporary reviews in suggesting that the neural signature of PGD integrates circuits for social

attachment, physical pain, and reward in a way that produces the characteristic agonizing mixture of craving and suffering, what the phenomenological tradition would recognize as anguish. (37,38)

Bodily Arousal and Emotional Regulation

Beyond the reward system, the neurobiological correlates of anguished grief encompass the broader psychophysiology of stress response and emotional regulation. The hypothalamic-pituitary-adrenal (HPA) axis shows a consistent pattern of dysregulation in bereaved individuals. Mean cortisol is higher and diurnal slopes are flatter than in non-bereaved controls, with morning levels running high. (41) A systematic review has shown that such alterations in cortisol are not uniform but are tempered by a host of variables including gender, age, one's proximity to the deceased, the severity of the grief and any accompanying depressive symptoms. Where prolonged grief disorder is concerned, the existing evidence supports the presence of HPA allostatic overload. (42)

The autonomic nervous system is similarly implicated. An attachment figure is a potent source of physiological co-regulation, and when they are gone that resource is lost. For the PGD patient it is a permanent absence, and the ensuing autonomic disarray is what lies behind the physical complaints of chest tightness, poor sleep, appetite changes and agitation. (41,43) From a polyvagal perspective, one might hypothesize that prolonged grief involves a change in autonomic tone. The constricted, agitated nature of embodied anguish is in keeping with heightened sympathetic arousal, whereas the numbness or frozen quality seen in some PGD cases could be read as a dorsal vagal reaction to distress that has become too much to bear. (44)

Emotional regulation is broadly impaired in PGD. The literature on complicated grief documents a consistent inability to either up- or down-regulate the affect coupled with a ruminative processing that serves to magnify distress rather than facilitating meaning. In a way these shortcomings in regulation and the neurobiological issues feed off one another in a self-perpetuating loop: the mechanisms for modulating anguish are compromised so the anguish lingers, and in turn the anguish keeps the system in a state of disarray.(43) This has clinical import. These findings suggest that an intervention confined to the cognitive dimension of grief are insufficient without concurrent attention to the neurobiological and embodied dimensions of anguished suffering.

Anguish as a Transdiagnostic Affective Process

The concept of transdiagnostic processes has gained increasing prominence in clinical psychology and psychiatry as a framework for understanding mechanisms that cut across conventional diagnostic categories and contribute to the maintenance of distress in multiple conditions simultaneously. Examples include rumination, emotional dysregulation, experiential avoidance, and attentional biases toward threat; all of which operate across depression, anxiety disorders, PTSD, and other conditions. (45,46) The argument developed in this article suggests that anguish, properly understood, deserves a place within this transdiagnostic repertoire.

Anguish is not specific to PGD but appears in recognizable form across a range of clinical conditions marked by severe existential suffering. Acute psychiatric emergencies, severe depressive episodes with prominent vital features, existential crisis states following traumatic medical diagnoses, and the acute phase of PTSD all include experiential dimensions that resemble what the phenomenological tradition calls anguish. PGD is particularly well suited as a paradigmatic case because the loss that precipitates it is always a loss of a relational other who was constitutive of the bereaved person's world, and because the anguish it generates is relatively tractable to phenomenological analysis. (30)

Anguish in PGD has features that distinguish it from its appearances in other conditions. The "presence in absence" quality gives PGD anguish a distinctive relational and temporal structure not found in, say, the anguish of a severe melancholic depression, where the sense of global threat and self-dissolution is not organized around an absent other but around the dissolution of the self's relationship to its own value and continuity. (25) The neurobiological substrate of PGD anguish, engaging the attachment-reward system in a way that depression and anxiety disorders do not, also suggests that even when anguish appears as a transdiagnostic process, its specific configuration in different disorders is not identical (6).

Proposing anguish as a formulation construct transdiagnostically has several practical benefits. It alerts clinicians to the possibility that anguish-like states may be present and clinically significant even in patients who do not meet full criteria for PGD. It provides a phenomenologically rich language for communicating with patients about their experience that may be more resonant than the symptom-focused language of diagnostic criteria. And it points toward shared mechanisms including the disruption of affective trust, the breakdown of temporal forward-projection, and the embodied experience of constriction, that may be amenable to similar therapeutic approaches regardless of the specific diagnostic context.

Clinical Assessment and Case Formulation of Anguished PGD

Assessing Anguish Beyond Symptom Checklists

Standard measures for PGD including the ICG (47), the PG-13-R (48), and the TGI-SR+ (49), have been developed and validated to operationalize the diagnostic criteria of ICD-11 and DSM-5-TR. These instruments provide reliable and valid assessments of PGD caseness, symptom severity, and functional impairment, and they are indispensable for research and clinical audit. However, by design, they focus on the symptom-level features of PGD rather than on the deeper affective structure that this article has been concerned to articulate.

The most frequently endorsed symptoms (intrusive thoughts related to the deceased, longing, and difficulty accepting the loss) are consistent with anguish but do not directly assess its

most distinctive features: the sense of felt constriction, the experience of temporal stasis, the dissolution of self–world belonging, and the quality of objectless, diffuse existential threat. Clinicians wishing to supplement standardized assessment with phenomenologically informed inquiry might consider attending to several additional dimensions. Questions about the patient's experience of time (whether time feels stopped or frozen, whether they feel unable to imagine a future without the deceased, whether ordinary daily rhythms have become meaningless) can elicit the temporal dimension of anguish. Questions about the body (whether the chest or abdomen feels tight or hollow, whether there is a pervasive sense of physical heaviness or constriction) can access the somatic depth of the experience. And questions about the sense of belonging and safety in the world (whether familiar places or relationships feel estranged, whether the world feels fundamentally unsafe or alien in a way that cannot be attributed to any specific threat) can illuminate the self–world disturbance that characterizes anguished PGD. (1)

Millar et al.'s (27) phenomenological survey provides a model for this kind of inquiry: through structured phenomenological interviewing using items derived from first-person accounts of grief, it is possible to differentiate the complex and multidimensional experiential landscape of bereavement with a fidelity that symptom checklists cannot achieve. The development of brief phenomenologically informed assessment modules represents a promising direction for clinical research and would allow the more granular formulation needed for individualized treatment planning.

Phenomenology-Informed Formulation

Case formulation in PGD has traditionally followed the structure of cognitive-behavioral and attachment-based models, identifying predisposing vulnerabilities, precipitating events, and perpetuating factors (including unhelpful cognitions, avoidance behaviors, and impaired social functioning) that maintain the grief response beyond expected duration. These models are clinically valuable and empirically grounded, and this article does not propose their abandonment. Rather, the phenomenological perspective developed here offers a complementary level of formulation that can deepen the clinician's understanding of the individual patient's experience and guide therapeutic focus. (50)

A phenomenology-informed formulation would attend explicitly to the following dimensions. First, the specific quality of the patient's anguish situates the patient's suffering within a richer clinical picture than diagnostic criteria alone provide. (27,35) Second, the formulation would address the function of anguish in the patient's experiential economy: for some patients, anguish may represent the only remaining affective connection to the deceased, so that its relinquishment feels like a second death (50); for others, it may be the expression of a profound violation of the assumptive world whose repair requires explicit attention to meaning-making and worldview reconstruction. (31) Third, the formulation would note the specific ways in which anguish disrupts the patient's temporal horizon since each of these configurations may call for different therapeutic emphases. (33) Fourth, it would identify the degree to which embodied anguish constitutes an independent clinical target requiring body-oriented or physiologically informed intervention alongside cognitive and relational approaches. (41,44)

The integration of phenomenological formulation with standard clinical assessment is not an aspiration toward philosophical abstraction but a practical clinical move: it ensures that the patient's experience is adequately understood before treatment goals are set, and that the chosen interventions are genuinely responsive to the nature and structure of the person's suffering rather than to a simplified model of their symptom profile.

Psychotherapeutic Approaches to Anguish in PGD

Existing PGD Treatments and Their Targets

The evidence base for psychotherapeutic interventions in pathological manifestations of grief has grown substantially over the past two decades, giving us a clearer picture of how to deal with the many facets of grief responses. (51) The intervention that has been put to the most rigorous test is Complicated Grief Therapy(CGT) now renamed as Prolonged Grief Disorder Therapy (PGDT). Developed by Katherine Shear and her team at Columbia University, PGDT is the gold standard in terms of validation. It is a framework that borrows from interpersonal psychotherapy, motivational interviewing and CBT in order to meet the particular needs of those suffering from an intense and drawn out form of grief. By way of structured exercises, the therapy is meant to put an end to the kind of pathological patterns that keep people stuck, such as avoidance or being unable to see a future without the person who has died. (52) The aim is to build a therapeutic alliance and restore a more adaptive way of living.

Moreover, LaPlante et al.'s (53) state-of-the-science review of psychotherapeutic interventions for PGD concludes that CBT-based approaches represent the current standard of evidence, with consistent effects on prolonged grief symptoms across individual, group, and increasing online formats. Recent network meta-analyses confirm this, identifying CBT and third-wave CBT as having the highest acceptability and strongest efficacy rates, while also validating psychodynamic therapy as a statistically significant, effective alternative for reducing PGD symptoms (54). Furthermore, a recent systematic review confirms CBT as the most prevalent and effective approach, while also noting promising results for hybrid approaches combining CBT with mindfulness, exposure therapy, or EMDR (particularly for grief complicated by trauma) (55). Meaning-centered approaches, drawing on Neimeyer's (2019) meaning reconstruction model and related frameworks, address the disruption of the assumptive world and the challenge of finding coherence and significance in a life altered by loss.

These existing treatments address several of the features of anguished PGD implicitly. The exposure work addresses avoidance of grief-related material (52), cognitive restructuring

targets unhelpful beliefs about the necessity of ongoing suffering or the impossibility of life without the deceased (50,56) and meaning-focused work engages the need to reconstitute a viable worldview after loss (57). However, the explicit conceptual framework of anguish is not consistently present in these treatment manuals, and the phenomenological aspects of the patient's experience may receive less systematic attention than the cognitive and behavioral ones. (27, 35)

Working Directly With Anguish

To properly manage Prolonged Grief Disorder (PGD) a therapist has to adopt an integrative approach. Since anguish can be regarded as an affective state of PGD, several therapeutic priorities must be woven into evidence-based work, each with a view to reframe how the patient lives with their grief and to foster healing.

There is a sense in which anguish tears at the relational fabric of a person's life, leaving a void where the usual scaffolding of reality should be. The therapist's role is to make up for that disruption. Not by trying to take the anguish away but by offering a safe place for it to be put on the table and worked through. Winnicott's holding environment, a steady, unanxious presence from the clinician can show the patient that what they are feeling is bearable, if not insurmountable. It is an environment that encourages them to voice their turmoil and explore its depths rather than shy away from it. (58)

Anguish in PGD may stem from not being able to put into words what one is going through. An integral part of the intervention has to be about helping the patient give expression to the rupture caused by their loss. This is more than simple psychoeducation; it is a form of self-inquiry to counteract the isolating sense that one's experience is beyond comprehension or description. (25,59) When a therapist helps a patient talk about the estrangement from the world or the stillness of time they feel, they restore a degree of meaning and communicability. Narrative and expressive tools are very useful here for a more nuanced telling of the story. (27,60)

In PGD the future is often seen as inextricably bound up with the deceased, a distortion of time that anguished grief brings with it. Therapeutic work, including techniques from Prolonged Grief Therapy (PGDT), should be aimed at putting those temporal and relational horizons back in order. The aim is to help the patient envision a future for themselves and rebuild their life narrative. The point is not to erase the memory of the person who died, but to make room for the loss as something transformative so it does not become an anchor. In this way the patient is empowered to move forward with their history rather than be held captive by it. (52)

PGD cannot be addressed on a purely cognitive level. There is a link between the body and anguish that research on autonomic dysregulation makes plain. (41,43) For patients whose grief is paralyzing and shows up in somatic ways, there is a need to bring in bodily interventions and mindfulness practices. These are not add-ons but essential for accessing the grieving process when narrative frameworks are out of reach. (25, 44)

A direct engagement with anguish in the context of PGD is a multifaceted process. Whether it is by providing a containing space, helping to articulate the pain, or addressing the body, the goal is to make grief therapy more effective and to guide the patient toward a healing that does justice to the complexity of their loss.

Therapist Experience and Ethical Considerations

Working therapeutically with a patient whose prolonged grief disorder has taken on an anguished form requires a deep grasp of not only the patient's psychological make-up but also the ethical weight of the process. The sheer force of that anguish can put a strain on the therapeutic alliance and impose a heavy emotional toll on the therapist, one that invites countertransference. Literature proposes a risk of vicarious grief when working with the many facets of a patient's loss. Hayes et al. (61) and Gelo (62) have shown how this can prompt a therapist to shy away from the bereaved person's suffering in favor of some premature reassurance, which has the effect of diminishing the patient's emotional turmoil.

There is an ethical obligation to meet the patient's pain head on and not let the overwhelming nature of their grief drive you to put up a shield. A phenomenological approach provides the right kind of conceptual framework for this; it lets the therapist see the anguish as a complex affective state in its own right and understand it on a level deeper than simple empathy. This framework enables the therapist to sustain grounded empathic presence in a grounded way without being entirely pulled under by the relational dynamics. Clinical supervision and personal therapy constitute necessary professional support. Figley (63) and Papadatou (64) make a compelling case for the support systems, both personal and organizational, that are needed to keep a practitioner resilient and to stave off compassion fatigue or vicarious traumatization as a matter of preserving work integrity.

Ethics also come into play in how the patient's anguish is interpreted. One has to be wary of pathologizing a grief response that is really just proportionate to the size of the loss. The work should make room for what that anguish means, treating it as an expression of existential and relational rupture rather than a symptom to be put in order. By validating the patient's experience in this manner, the therapists are not only asking them to endure but are creating the conditions where anguish can be transformed and healing can take place. That commitment to understanding is what ultimately strengthens the therapeutic alliance.

Future Directions

The argument of this article has been that anguish deserves conceptual rehabilitation as a clinical and psychopathological category, and that PGD provides a uniquely illuminating context in which to develop this rehabilitation. Several directions for future inquiry follow directly from the analysis.

Clinical psychology has made a significant stride in its ability to appraise the more complex aspects of anguish with the creation of assessment tools that are firmly rooted in phenom-

enology. This is especially true when it comes to Prolonged Grief Disorder (PGD) and kindred psychopathologies. To be of any use, these instruments have to make sense of the methodological gap between the kind of first-person inquiry one finds in phenomenology and the rigour of standard psychometrics. When researchers put together the qualitative markers (the subjective, lived experience) with quantitative clinical measures, they can build something robust enough to do justice to the many facets of anguish. In this way we may get empirical data that puts the role of anguish in PGD into sharper relief, giving us a finer grasp of its phenomenology. (27,35)

For the moment, the link between how anguish is described phenomenologically and what we see in neurobiological studies is still something of an open question; we can point to correlations but not yet to cause and effect. (37,38) That will change as future work makes use of neuroimaging and psychophysiology to zero in on the neural correlates of anguish's defining features. It is only by doing so that we can properly bring biological paradigms and phenomenological views into alignment. The payoff would be a richer theoretical picture and, down the line, some novel ways of treating patients.

Randomized controlled trials of therapies are necessary put together with the specific intent of dealing with the anguish in PGD. The existing literature is limited for interventions aimed at these particular experiential elements. Multimodal trials that used outcome measures for anguish in addition to the usual PGD symptom checklists, would provide a more holistic understanding. Delineating the value of an approach that puts the patient's experience of anguish front and center would go a long way to justify a more nuanced focus in the clinic. (54)

One cannot overlook the fact that anguish is shaped by the cultural milieu in which it occurs, be it in matters of loss or selfhood. Studies that look at how different cultures narrate and respond to anguish would add much to the conversation and inform practice in a more sensitive manner. (65)Then there is the matter of comparing diagnostic groups to see where the commonalities lie in this transdiagnostic affective process, which could point us toward better tailored interventions. (66) These kinds of investigations serve as a reminder that anguish is as much a culturally embedded experience as it is a psychological one, born of the interplay between the individual and the collective.

Conclusion

One cannot put the suffering of a PGD patient into words with any set of criteria or symptoms. There is something more to it, a kind of phenomenological architecture made up of estrangement, rupture and constriction for which the term anguish is a proper fit. If clinicians and therapists give this structure the attention it warrants, they will come to a better understanding of what their patients are going through and be in a position to offer a response that does justice to the depth of their pain. In this way, PGD is the paradigmatic case for learning about anguish. Its ties to loss and love, and to the very fragility of relational existence, are irreducible. It presents a clinical context where one can study anguish on its own terms, rather than whittling it down to a set of diagnostic symptoms. The point is not to pathologize grief, but to see when the bereaved has become chronically constricted in his relation to self, body and world. To name that is to preserve the meaning of the bond at the source of the suffering while still being able to meet the patient where they are.

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