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Not All Grief Is the Same: Presentations of Grieving Clients Attending Emotion-Focused Therapy

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ABSTRACT

Background: Research on grief has extensively categorised different characteristics that affect the grieving process, such as coping styles and risk factors. Despite this, there is still a relative lack of phenomenological descriptions of the typologies of grief complications.

Purpose: This study aimed to develop a comprehensive set of categories and typologies of grief complications through a qualitative analysis of therapeutic sessions conducted within the framework of Emotion-Focused Therapy for individuals experiencing Complicated Grief.

Method: Using ideal-type analysis and theoretically informed descriptive-interpretive qualitative research, the researchers analysed video and transcript data from 26 participants (76 sessions in total).

Findings: The study presents categories (e.g., multiple losses) of complications across seven domains, such as the nature of the death, the relationship with the deceased, emotional experiences and emotional difficulties, problematic self-treatments, symptoms and contextual stressors. Furthermore, six ideal types of grief complication were found: 1. Broken/Shocked by the Death; 2. Vulnerable Without You; 3. The Lost Paradise; 4. You Left Me All Alone; 5. Regret and Guilt Over Non-Action; 6. The Death Prevents Any Chance of Resolution of Conflicts.

Conclusions: The findings highlight that complications often emerge from core emotional processes (e.g., unresolved attachment injuries) rather than symptoms alone. This typology offers a phenomenologically and clinically relevant framework for understanding the heterogeneity of grief complications, suggesting a more tailored therapeutic approach for various types of grief complications.

1 | Introduction

Grief is the emotional process that occurs in the face of loss. When this loss refers to a person, we speak of bereavement-related grief. Although most people have sufficient resources to process loss, in some cases complications arise, which may lead to what has been termed Persistent Complex Bereavement Disorder (PCBD), Complicated Grief (CG) or Prolonged Grief (PG) (Boelen and Lenferink 2020). Individuals affected by complicated grief need and benefit from psychological interventions (Neimeyer and Currier 2009), even though some do not find such help effective (Wittouck et al. 2011). This is partly due to

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Public Significant Statement

This study shows that not all grief is the same: people experience different types of complications in grief, such as shock, dependency, or unresolved conflicts, which call for tailored therapeutic approaches. Understanding these variations can help society and clinicians better support grieving individuals and reduce suffering.

Implications for Practice

- Tailored interventions: Therapists should adapt interventions to the type of grief complication (e.g., trauma-based, dependency-based, self-critical, unfinished-business) rather than applying uniform grief protocols. This allows for more precise and effective emotion-focused work.
- Focus on emotional processes, not only symptoms: Complicated grief often stems from blocked emotional processes (e.g., shame, fear, or unresolved attachment injuries). Therapy should therefore prioritise emotional accessibility, regulation, and transformation rather than symptom reduction alone.
- Identify the central emotional block: Practitioners should help clients identify and work through the specific emotion that sustains the complication (e.g., shame, fear, guilt, or loneliness), enabling the emergence of adaptive emotions, such as sadness and compassion.

Implication for Policy

- Promote emotionally informed approaches in bereavement care: Mental-health services and bereavement programs should move beyond symptom-focused models and incorporate emotionally informed frameworks that address the experiential and relational dimensions of loss, as highlighted in Emotion-Focused Therapy.

the inherent idiosyncrasy of grief processes, which are shaped by various factors, such as social, cultural, and individual variables (Aeschlimann et al. 2024; Buur et al. 2024). The idiocrasy of the grief processes calls for more phenomenological studies, particularly when these processes are complicated.

Previous research has examined risk factors (Buur et al. 2024), profiles of symptomatology (Boelen et al. 2023), coping styles (Gamino et al. 2020), and population-specific experiences (Mota et al. 2023; Falzarano et al. 2022). However, these approaches tend to focus either on symptom dimensions, demographic correlates, or coping mechanisms and thus fall short of providing an integrative typology of grief complications. Better understanding of grief complications can inform the development of therapeutic interventions addressing these difficulties. Studying grief processes as they are presented in the therapeutic context offers a unique opportunity to learn about the grief as the clients in therapy focus on the core of what aches them in losing someone close to them.

Emotion-Focused Therapy (EFT) is a neo-humanistic therapy that synthesises the person-centered tradition and the focus on present experience from Gestalt therapy (Greenberg 2017). As its name indicates, this therapy focuses on emotion and understands it as a fundamental datum of existence and of the change process (Greenberg 2017; Jódar and Caro 2023). One of the main contributions of this therapy is its differentiated view of emotional typologies. Thus, core or nuclear emotions are understood as primary emotions, which constitute the individual's initial reaction to a situation (Greenberg 2017). These primary emotions can be: (1) adaptive, when they are congruent with the situation and lead to adaptive action tendencies; or (2) maladaptive, when they are not fully congruent with the context and instead arise from historical pain and unfinished business that are activated in the present (e.g., when a supervisor raises their voice and the person re-experiences the same fear felt in the presence of an abusive parent; Greenberg 2017; Jódar and Caro 2023). In addition, secondary emotions can be a mixture of emotions, such as a diffuse and undifferentiated sense of distress (global distress; Pascual-Leone and Greenberg 2007), or discrete emotions that arise in response to other emotions and serve a regulatory function with respect to emotional pain (e.g., anger regulating vulnerability). Finally, instrumental emotions refer to feigned or strategically expressed emotions that aim to manipulate or elicit a specific response from others (Jódar and Caro 2023).

As highlighted by authors such as Gamoneda et al. (2025) and Sharbanee and Greenberg (2022), this therapy may be especially useful in grief due to its focus on experience and emotional processing and its understanding of grief complications as, fundamentally, emotional complications. Studying the variations in grief among clients who sought EFT in order to address their loss and associated painful emotional experiences offers a unique perspective as people in therapy, who are met with a caring and compassionate other, are particularly open about what is concretely complicated and painful about their loss and grieving. This study aimed to generate conceptual categories and typologies that allow detailed and differentiated descriptions of the various clinical and experiential manifestations of complicated grief.

2 | Method

2.1 | Design

This qualitative study drew upon elements of ideal-type analysis (Stapley et al. 2021), and theoretically informed descriptive-interpretive qualitative research (Elliott and Timulak 2021). Transcripts and video recordings of therapy sessions were analysed.

2.2 | Participants

The participants in this study were a total of 26 individuals with complicated grief (score ≥ 25 on the Inventory of Complicated Grief; ICG). The presence of complicated grief was established following the criteria of Prigerson et al. (1995), considering a score equal to or greater than 25 on the ICG. Participants ranged from 25 to 61 years ($M = 42.3$, $SD = 10.7$), including 25 females and one male, and were of Spanish ($n = 19$), Venezuelan ($n = 6$), and Colombian ($n = 1$) nationality. To participate in the study, individuals were required to meet the

following criteria: to be undergoing a process of complicated grief; to have provided informed consent for the sessions to be recorded; to have experienced the loss at least 1 year prior to the start of the intervention; to be over 18 years of age; and to present a certain degree of emotional activation with regards to the loss. Exclusion criteria included: not meeting the criteria for complicated grief; presenting with an eating disorder or a psychotic disorder; substance use; taking anxiolytic medication; not having access to a computer with a camera and stable internet connection; or lacking sufficient privacy to complete the sessions. Individuals were also excluded if they did not authorise the recording of the sessions, were undergoing another type of psychotherapy, or did not show signs of emotional distress when talking about the deceased (for more details, see the original study by Gamoneda et al. 2025).

2.3 | Researchers

There was a total of four researchers (two males, two females), aged between 25 and 33 years, who analysed the videos and transcripts. These researchers had clinical experience in EFT, ranging from two to 10 years, and were acquainted with the EFT perspective on grief and its complications. They were also familiar with general grief theory and research (e.g., Buur et al. 2024). Two of these researchers were also therapists; however, they did not analyse their own cases in order to avoid potential conflict of interest.

2.4 | Data Collection

Participants were recruited through word of mouth and social media. Upon initial contact, they completed a preliminary screening interview to assess eligibility criteria, during which they were informed about the study and provided written informed consent. Participants attended three therapy sessions in tele-therapy format (the study was conducted during the COVID-19 pandemic): the first session focused on exploring grief complications and establishing a therapeutic bond; the second session involved EFT's Empty-Chair Task for CG; and the third session centred on meaning-making. The therapy sessions (lasting between 50 and 90 min) were recorded. These sessions were transcribed and translated by the first author of the study with the help of the Happy Scribe software. For further details of this procedure, see the original study by Gamoneda et al. (2025).

2.5 | Data Analysis

Data analysis comprised two approaches: theoretically informed descriptive-interpretive qualitative analysis (Elliott and Timulak 2021) and ideal-type analysis (Stapley et al. 2021).

Prior to viewing the video recordings, the researchers who analysed the videos and transcripts completed a 4-h training, conducted by the first author, focused on general grief theory and the proposed qualitative methodology to ensure adherence to the analytic process. This training involved reviewing video recordings and transcripts and carrying out the proposed analytic procedures, using materials that were not part of the dataset included in the present study. The researchers saw between 4 and 16 participants, while the first author had seen all the cases. The first, second, and last authors, already familiar with the sample through their involvement in other studies based on the same sample (Gamoneda et al. 2025), provided feedback on each analysis conducted by the researchers.

The analysis was conducted using both the transcripts and the videos, with a total of 76 videos (24 first sessions, 26 s sessions, and 26 third sessions) and 26 participants. For two participants, the first sessions were not viewed because they were not recorded due to technical problems.

2.5.1 | Descriptive-Interpretive Analysis

The theoretically informed domains were defined before the analysis, in line with the methodology described by Elliott and Timulak (2021), and included: (a) type and form of death; (b) emotions and experiences that complicate grief (e.g., intense guilt); (c) relationships with the deceased prior death; (d) relevant problematic self-treatment of the grieving person (e.g., chronic self-criticism); (e) emotion processing difficulties (i.e., difficulties of emotion accessibility, regulation, productivity relevant for grieving); (f) symptoms and/or symptom level emotions indicative of complicated grieving; (g) Other contextual circumstances around or after the death that may have complicated grieving. While these domains of investigation were predetermined, there was an openness to include other domains or restructure pre-determined ones.

The four researchers watched the video, used the transcript of the video, highlighted all parts of the transcript that were relevant to the grief presentation, assigned each highlighted part to one of the pre-defined domains and divided highlighted parts of the transcript into meaning units, essentially short paragraphs. They also provided a tentative description/category of the highlighted segment/meaning unit. For example, if a client expresses feeling fragile and lost without the deceased, this could be noted as a tentative category (e.g., fragility–dependence or "I can't live without you") related to grief complications. While the tentative category was close to the clients' exact words and nonverbal presentation in the three sessions, the researchers were all informed by EFT and grief theory and thus their succinct descriptions/categories can be considered involving an interpretive element anchored in EFT and grief theory. Thus, the tentative categories, while assigned to pre-determined domains, were inductively derived within those domains.

The analysis was conducted by each of the four researchers separately and then reviewed by the first author, who reviewed both the tentative categories and the session transcripts from which those tentative categories were derived. The first author consolidated the tentative categories into the final ones; this process was also audited by the second and last authors. Saturation was reached after the analysis of 20 participants, such that the remaining cases reviewed (i.e., six participants) did not yield any new categories. While the majority of data came from the expressions of the clients in the session, a small minority of data was based on the researchers' observations of the process (e.g., intense arousal, as shown in Table 1). The researchers' observations thus

TABLE 1 | Categories of grief complications across theoretically informed domains.

Domain	Category (*n*)	Description/examples and quotes
Type and form of death	Traumatic or unnatural loss and/or sudden death (21/26)	Overdose, medical negligence, suicide, car accident, death of a child. Quote: "Your mother has a pain in her side that she can't breathe. I say: But in the side, it's like this, a horrible pain. She's screaming."
	Multiple losses (12/26)	Current loss present in the context of various historical losses. Quote: "And my mother has also died, and a brother of mine has died."
	Long and complicated process of dying (7/26)	Slow and painful processes, witnessing physical change, pain or degeneration of the other. Quote: "She started to get ill and was diagnosed with myeloma. And then it lasted three years."
Emotions and experiences that complicate grief	Losses beyond death (26/26)	Losses related to expectations, roles or relationships. Quote: "I've lost out as a woman, as a couple, as everything. You see, my life no longer has meaning. It's not the same."
	Fear—pre-existing fragility (20/26)	Sense of self as fragile from before death. Quote: "That's where I missed you the most. More than because of knowing that we were alone and knowing that we didn't have anyone who could save us."
	Grief-sadness about the future without the deceased (17/26)	Losing life plans or expectations. Quote: "I will never hear Mum from my daughter again."
	Difficulties in experiencing connection/ presence or adaptive experiences (16/26)	Struggles with reorientation, meaning, or adaptive experiences. Quote: "I isolated myself, and I have not gone out or met with other couples again."
	Fear-anxiety about oneself or others (15/26)	Fear something could happen to other loved ones. Quote: "It's true that I tell you that in the face of fear, that is, in the face of the fear of facing the loss of María, I also have the fear of losing, of losing those I have here."
	Alone and without the love of the deceased (14/26)	Missing connection, missing feeling special. Quote: "I don't feel special with anyone, not like with him."
	Anger at others related to the death (14/26)	Doctors, relatives preventing goodbyes, others forgetting deceased. Quote: "I don't know, because I went crazy riding the nurse on her chest and telling her that they had killed her and that they had killed me. And that was it, that was it."
	Anger toward the deceased (13/26)	Anger preceding the death or associated with it. Quote: "I read the report and stuff, the blame I mean, I blamed my daughter, as if she was the only one to blame."
	Experience of loneliness and fragility in the face of something overwhelming (11/26)	Significant daily impact on taking care of family, children... Quote: "And now I am alone being a parent; we are no longer parents together, it's just too hard".
	Traumatic experiences prior to the death (10/26)	Previous traumatic events complicating grief. Quote: "It was the fact that you are living a year with drugs in your house and you experience very heavy moments, moments in which you question many things, moments in which you see the people you love, who are not the people you know. You see a lot of fights."
	Feeling guilt about conflicts (e.g., fights, neglecting the deceased before the death) (10/26)	Guilt-remorse about conflicts with the deceased. Quote: "The last thing I said to my cousin was 'I hope you die.'"
	Personal wound (10/26)	Personal wound, damaged to the self caused by the loss and the death. A perceived loss of a part of oneself, undermining one's sense of self. Quote: "When the person died, something inside me died too and... I don't think or feel the same way anymore."
	Secondary losses (9/26)	Changes in relationships, family breakdown. Quote: "Directly it was as if he were absent. He lived, he got up, he ate, he behaved in a certain way, but he was as if he were absent, it wasn't him, I couldn't find in him the communication that... From then on, even our marriage, our relationship, has not been the same..." (referring to the husband following the death of their daughter)
	Fear of death (5/26)	General fear of mortality. Quote: "The same thing that happened to my brother and my aunt is going to happen to me."

(Continues)

TABLE 1 | (Continued)

Domain	Category (*n*)	Description/examples and quotes
	Guilt about the death of the close one (5/26)	Having caused the death (e.g., by not preventing it). Quote: "I have blamed myself, wondering whether I caused her illness because of the huge disappointment she felt because of me...."
	Guilt about continuing life after the death of close one (4/26)	Not remembering enough, not honouring deceased (e.g., cemetery visits). Quote: "One thing I also wanted to mention is that there are times when I feel remorse for not feeling as bad as I should."
	Missing contact in the future (2/26)	Connection or love with the deceased that is lost (e.g., feeling a lot of love to give to the deceased that it's lost). Quote: "I had a lot of love to give you, maybe not luxuries, but a lot of love"
Relationship with the deceased	Good-positive relationship (20/26)	Loss of connection, love, validation, safety. Quote: "You are the person who made me feel that I belonged in the family. The only person who made me not feel like a weirdo. Who made me not feel out of place. The only person who defended me in front of my stepfather."
	Fusional-dependent relationship (19/26)	Fragility without the other, dependant relationship with the deceased. Quote: "I had a very close relationship with my mother, a total union. And well, for me my mother was everything. If my mother came to my house 15 times, those were 15 times we kissed. And we clung to each other and held each other tightly."
	Attachment figure (16/26)	Deceased was primary caregiver. Quote: "I felt very protected with my mother, very protected."
	Centrality of the deceased for the bereaved (13/26)	Loss of the other when they were a key figure for the griever functioning (e.g., loss during childhood). Quote: "Well, I mean, it's the law of life. But not at 14 years old, of course (referring to losing a parent at that age)."
	Pre-existing unfinished business (6/26)	Ambivalent or complicated relationship (previous conflicts). Quote: "I mean, what remains most, what hurts me the most is: I suffered a lot, and you had the opportunity to protect me, but you didn't (expressed to the deceased in the empty-chair dialogue)."
Problematic Self-treatments	Self-interruption/ behavioural avoidance (23/26)	Avoiding emotions linked to the loss via humour, rationalisation... Quote: "And sometimes I do something that turns me off, it's like a switch. Simply when I feel that I am reaching the limit of my tolerance, where I know that if I stay there, it might be very difficult for me to get out of it. I think about something superficial, the stupidest thing I can think of, and I focus on it."
	Criticism related to the death or the deceased (19/26)	Self-blame for neglect, rejection, or forgetting or other reasons. Sometimes related to a global shame or low self-wort. Quote: "I told her to die, I'm a monster"
	Secondary self-criticism (17/26)	Blocking primary sadness with self-demands (e.g., I must be happy, get over it...). Quote: "No, you can't be like this, you can't be like this, you have to keep going and give me strength, but in his own way"
	Rumination about the other or death (15/26)	What could have been done differently to prevented the death or to resolve past conflicts. Quote: "I can't stop thinking about it, going over it and over it in my head, wondering every day what I could have done or what I could have done to avoid it, or how badly I behaved, or what I did this or how everything would have been."
	Worry (13/26)	Present-future concerns related to death. Quote: "I'm really afraid of loving someone again... not giving a shit about me... dying without caring."
Emotion processing difficulties	Dysregulation/self-collapse (18/26)	Intense emotions block meaning-making.[a]
	Intense arousal (17/26)	Collapse and suffering, hard to make meaning from emotions.[a]
	External voice—narrative (16/26)	Focus on narrative not on emotion/experience.[a]
	No attention to emotions (16/26)	Difficulty attending to emotion.[a]
	Fantasy-idealisation of the other (14/26)	Fantasy or idealisation aimed at avoiding the pain of the death.[a]
	Non-acceptance of emotion(s) (14/26)	Rejection of emotional experience.[a]
	No agency (13/26)	Feeling like a passive victim of emotion.[a]
	Difficulty in symbolization (12/26)	Problems creating meaning from emotions.[a]

(Continues)

TABLE 1 | (Continued)

Domain	Category (*n*)	Description/examples and quotes
	Difficulty in differentiation (12/26)	To experience the same emotions without change, feeling stuck.[a]
	Low arousal (9/26)	Prevents emotional processing.[a]
	Incongruence (5/26)	E.g., smiling when talking about pain.[a]
Symptoms/ secondary emotions	Hopelessness-helplessness (23/26)	Undifferentiated distress, sense of powerlessness and defeat. Quote: "There's no way to fill that absence with anything."
	Anxiety-fear (21/26)	Excessive worry or dread. Quote: "Because of my anxiety I had to leave my life, I couldn't work, I had to leave university."
	Lack of meaning (9/26)	Loss of purpose in life. Quote: "I complain, because I can't find meaning. So, I lost my wife, I lost my future, I lost my roadmap through life."
	Depression (9/26)	Prior diagnosis of depression, which may have constituted a vulnerability factor that complicated the grieving process. Quote: "I was diagnosed with depression even before I lost him..."
	Psychosomatic symptoms (6/26)	Physical symptoms without clear medical cause. Quote: "Yes. Yes. It even raises my blood pressure, a lot. It goes through the roof. Because I'm not very expressive, in the sense that there are people who are, but not me."
	Dissociation (6/26)	Detachment from self or reality or emotion.[a]
	Suicidal ideation (5/26)	Thoughts of ending life. Quote: "Sometimes I wanted to leave this life. And I didn't care if I was alive or not, because I felt that I had nothing left."
	Fear of forgetting (5/26)	Anxiety about forgetting deceased. Quote: "I don't remember that well his voice, I am worried about losing more thing of him..."
	Panic attacks (4/26)	Sudden episodes of intense fear-anxiety. Quote: "the only thing I know is that when they told me, I don't know what came over me, that well, I got dizzy, I had an anxiety attack and I fainted."
	Agoraphobia (2/26)	Avoidance of places/situations. Quote: "After that I couldn't leave home."
	Hypochondria (2/26)	Health anxiety, fear of illness. Quote: "I'm very hypochondriacal."
	Sleeping problems (2/26)	Difficulty initiating or maintaining sleep. Quote: "When I'm alone it's hard for me to sleep, when I'm in company that I'm in another place, I manage to get a full night's sleep when I'm alone in my space and it's hard."
	Fibromyalgia (1/26)	Prior diagnosis of fibromyalgia, which may have constituted a vulnerability factor that complicated the grieving process. Quote: "Then I have fibromyalgia. As a result of everything I went through, I was diagnosed with fibromyalgia a few years ago."
Other contextual circumstances around or after the death	Loneliness and lack of support (21/26)	Lack of support, judgement from others. Quote: "Sadness has to come naturally, it's part of it too, just like being happy, but it seems that in the eyes of society, as some time has passed, it shouldn't be like that. Six years have passed and it's not something that should be mourned."
	Chronic loneliness (15/26)	Loneliness present even before death, which exacerbated the loss and made it more difficult to process due to the absence of a support network. Quote: "We always felt alone, but in reality, we were with ourselves and we never realised it."
	Issues-conflicts with others (15/26)	Family or friends' conflicts that complicates grief. Quote: "When aunt died, there was this one man who excluded me from parties and celebrations."
	Social/economic complications (14/26)	Social stressors adding to grief processing (e.g., unemployment or economic difficulties). Quote: "Yes, because of the economic situation, because of the situation, yes, it was more difficult."
	Not being able to say goodbye (9/26)	No farewell or closure. Quote: "That's what's on my mind the most, with my sister, who hadn't been with us (when she died). And then not being able to say goodbye"
	Health problems (9/26)	Illnesses of the bereaved that hinder the grieving process (e.g., by preventing them from attending to farewell rituals). Quote: "She died while I was undergoing surgery, I did not know she had died until weeks later."
	Neglecting own grief (5/26)	Prioritising others and their pain. Quote: "And well, on top of that my husband, because I was very worried about my husband, because my husband did go into shock."
	Perceived inappropriate delivery of the news about the death (5/26)	Cold, unprepared ways of giving the news of death, lack of information. Quote: "And I was called by the firefighter, who told me that my daughter had died. For me that was horrible. Horrible, because I also felt very bad, because I was in an office where 20 people worked."

(Continues)

TABLE 1 | (Continued)

Domain	Category (*n*)	Description/examples and quotes
	Disenfranchised grief (5/26)	Socially unsupported or rejected grief. Quote: "When I go to her mum's house and I see that she has photos of her young children, her nephews, her brothers and sisters in the living room. And not seeing a photo of my daughter there hurts, all the time. And she has it, I printed it for her, I gave it to her so that she would have a photo of her granddaughter with her grandson."
	Religious beliefs hindering assimilation (5/26)	Spiritual beliefs that block the grieving process (e.g., Suicide prevents rest; suffering traps deceased). Quote: "I go back again to beliefs, and in those beliefs, we're taught that souls suffer—they suffer when their loved ones are suffering. And I tell myself that too: that my suffering might not let her go in peace, that my suffering might not let her rest in peace."

Note: Frequencies are reported solely to indicate relative prominence within this set of cases, and not to infer population prevalence.
[a]There are no quotes for emotion processing difficulties domain, dissociation category (in symptoms/secondary emotions domain) because these refers to information derived from the observed emotional process in the session rather than from isolated verbal statement. At times, the quotes may appear as if the bereaved person is speaking directly to the deceased; this is because they were produced in the context of a task in which the participant spoke to him/her in imagination.

also could be used as meaning units from which the tentative and then the consolidated categories were developed.

2.5.2 | Ideal Types Analysis

In addition to descriptive-interpretative analysis, for each case, a Grief Case Reconstruction was written, as proposed by Ideal-Type Analysis (Stapley et al. 2021). This case reconstruction was a summary of the case focused on grief-related difficulties. Given his familiarity with the sample, the first author was involved in the analysis and case reconstruction of each case. The second and last authors then provided feedback on the summaries (of the case reconstructions). The summaries of the case reconstructions were compared for similarities and differences and organised by the first author into distinct types of complicated grief. Case reconstructions were developed iteratively and compared across cases. Through this comparative process, each new case reconstruction either led to the identification of a new type or was integrated into an existing one. Typological saturation was reached after 11 cases, as no additional typologies emerged following the analysis and comparison of subsequent case reconstructions. Once this classification was completed, an optimal case (Stapley et al. 2021) was chosen for each type that was the best example of that type. This case served as a guide for comparison between and within types. Based on this optimal case, the different types were described by the first author of the study as Ideal-Type Analysis (Stapley et al. 2021) proposes. Once this description was completed, it was discussed with the research team, and the pertinent modifications were made. The changes concerned the addition of descriptions of elements such as nightmares and active avoidance in Type 1, as well as further explanations of key elements (e.g., fantasy in Type 4 and its regulatory function) across the different types (see Table 2).

To assess the representativeness of the ideal types with respect to the data from this sample, credibility checks were conducted (Stapley et al. 2021). In this regard, the first (JG) and third (TR) authors classified the cases into the different types, assigning each case to a single type. An agreement percentage of 50% was reached. After reaching 50% agreement, the two authors held a meeting to discuss the differences and classification choices, leading to further modifications. The differences served to contrast and change certain aspects of the described ideal types, in order to improve their representativeness, clarity, and classification power. The changes were that the differentiation between Types 1 and 2 was added to the description of Type 2, and the differentiation between Types 3 and 4 was added to the description of Type 4 (see Table 2). Once this was done, the fifth author (JM) carried out this classification based on the cases reconstructions, without knowing the first classification made by the authors (JG and TR). An agreement of 73% was reached between JG and JM. Regarding the 27% of discrepancies, their origin was examined and discussed (e.g., one author had additional information from having viewed the session videos), and full consensus (100%) was reached. The final ideal types were audited by the second and last authors. These classifications were conducted using the written summaries and were based on the predominant characteristic of the complication (e.g., fantasy, fragility), as reflected in the descriptions and in Table 2.

2.6 | Ethics

All participants provided informed consent prior to participation. Data were fully anonymised and securely stored in accordance with ethical and data protection regulations. The study and its procedures received approval from the Ethics Committee of the Universidad Pontificia Comillas under the report number 14122020.

3 | Findings

3.1 | Theoretically Informed Descriptive-Interpretive Analysis of Complicated Grief

We first present aspects of complicated grief across the theoretically informed domains of investigation. The domains are as follows: 1. Type and form of the death; 2. Emotions and experiences that complicate grief; 3. Relationship with the deceased; 4. Problematic self-treatments; 5. Emotion processing difficulties; 6. Symptoms and secondary emotions; and 7. Other contextual circumstances around or after the death that may have complicated grieving.

Type and form of death refers to the specific types of death or the dying process that may have influenced grief complications. Emotions and experiences that complicate grief denote emotions that can interfere with the grieving process by blocking the

TABLE 2 | Types of complications.

Type of complication	Main difficulty/features	Case
Type 1: broken/shocked by the death – unbearable loss ($n=4$)	Intense pain without the deceased	Mrs. Y lost her 10-day-old daughter under unclear circumstances, experiencing profound despair and an irreparable brokenness
Type 2: vulnerable without you – unprotected and unable to function alone ($n=12$)	Fragility/fear without the deceased	Mrs. K lost her mother, her sole protective figure, and remains unable to cope alone despite time passed
Type: 3 the lost paradise – loss that cannot be replaced ($n=3$)	Fantasy to avoid core emotions (shame, loneliness and fear) that were not exclusively related to the deceased	Mrs. J idealises her late ex-partner, imagining the perfect future lost with his death
Type 4: you left me all alone – and your presence/love cannot be replaced ($n=3$)	Loneliness without the deceased	Mrs. N lost her mother, the only figure who made her feel loved and valued, now feeling profound isolation.
Type 5: regret and guilt over non-action pertaining to the deceased – triggering core shame and self-criticism ($n=1$)	Self-criticism and shame	Mrs. U feels unforgivable for "failing" her husband during her illness, which evokes chronic shame
Type 6: the death prevents any chance of resolution of conflicts and problems prior to the death ($n=3$)	Problems and conflicts with the deceased prior to death	Mrs. P lost her ambivalent father, struggling with unresolved need for his approval and suppressed anger

Note: Frequencies are reported solely to indicate relative prominence within this set of cases, and not to infer population prevalence. $N=26$.

sadness related to the loss or other adaptive experiences, or by virtue of their intensity. They may either have been chronic prior to the death or emerged afterwards. Relationship with the deceased concerns the nature of the relationship with the deceased that complicated the grieving process—either because it was positive or marked by dependency, where the bereaved cannot find in other relationships what they had with the deceased (e.g., love), or because it was a conflictive relationship that makes the grieving process more complex. Problematic self-treatments refers to self-self processes present at least since the time of the death, which may be related to emotional pain and act as a block to the grieving process. Other contextual circumstances around or after the death that complicate grief describes circumstances that may hinder the grieving process, either because there is no legitimate space to experience the grief, or because they function as stressors that block and freeze the grieving process. Emotion processing difficulties refers to difficulties in emotion accessibility, regulation or productivity (i.e., emotional processing related to therapeutic change, such as processing an emotion in an agentic versus a non-agentic manner) which can complicate the grieving process by hindering the effective processing of emotions related to complications. Finally, symptoms or secondary emotions concerns experiences that, by both overshadowing primary emotions and generating distress through their intensity, contribute to grief complications.

Within each domain, we outline its various aspects through categories that represent it. Categories are presented along with their frequency to how many participants they pertained in the data. This is used to provide information of the representativeness of categories within the sample. Given that this is a qualitative study, it needs not to be confused with the representation in the population, as the absence of a category in the descriptions provided by a participant does not mean that it is not present in their experience, but simply that it was not spontaneously mentioned in the context of the therapy sessions. These categories, along with their descriptions and frequencies, are provided in Table 1.

Not all thematic categories were dominant or directly accessible in every case, and several participants showed partial or indirect expressions of some categories. Thus, we can find several examples of this across different categories, such as *fear of forgetting* (e.g., "And if I say my niece isn't there, she accepts that she's gone. And right now, I don't want to. I don't want to forget my niece".) and *sleeping problems* (e.g., "In fact, sometimes when I'm really anxious, I get sleep paralysis.").

3.2 | Types of Complications in Grief—Ideal Types Analysis

The complications in grief can be related to the quality of the relationship with the deceased before their death, but also to circumstances of the death, emotional experiences of loss, regrets or self-criticism related to death, etc. We now review different types of grief complications that the ideal types analysis yielded. Each type is described first, followed by an illustrative optimal case whose details have been modified to ensure anonymity. These types are summarised in Table 2, together with their main features.

3.2.1 | Type 1: Broken/Shocked by the Death—Unbearable Loss ($n=4$)

3.2.1.1 | General Description. This type of complicated grief presentation was characterised by shock attributed to the death. The death was experienced as a trauma, and sudden or unnatural

deaths (e.g., the death of a child) may fit into this category, as they represent a rupture in the self and the person's life narrative: the bereaved may have felt irreparably broken. In this case, grief became complicated due to the nature of the death itself (e.g., suicide). Sometimes, the experience shifted toward fear, and other times toward a profound sense of brokenness and the unbearable pain of the loss, such as the death of a child. Sometimes the feeling of fear was not present, but what was present—and was the defining characteristic of this type—was the pain experienced as a deep, tearing wound, a pain that was felt as unbearable and is directly tied to the loss. In this type of complication, we observed experiences such as guilt (e.g., for not noticing warning signs before a suicide), self-criticism, or worry, which are secondary to shame, the pain of the loss, or a sense of fear and fragility.

The bereaved experienced these emotions with intense arousal, perceiving their emotional experience as overwhelming and beyond their capacities, leading to self-collapse and attempts to avoid it. It was also common to find the presence of nightmares and death-related images and a certain tendency to avoid the painful experience. In addition, partly due to the intensity of the experience, there may be a sense of being alone in the grieving process, or a feeling of being misunderstood in grief. The relationship with the deceased was usually predominantly positive, so the complications were not typically related to unfinished business or past conflicts, but rather to the trauma of the death itself.

3.2.1.2 | Optimal Case. Mr. Y lost his 10-day-old daughter under medically unclear circumstances, without an autopsy. The death was experienced as an existential fracture—as if a part of himself had been irreparably broken, as if he had died with her. Since then, Mr. Y has lived with grief marked by intense sadness, constant pain, and a sense of loss that remains as vivid as on the first day. The absence is present in his daily life, and when he fully feels it, his emotional arousal escalates to the point of overflowing, leading him to collapse into despair, helplessness, and intense vulnerability. The loss is multifaceted: the bond, the shared future, his role as a father, and a family structure that falls apart. He deeply felt the pain of not having been able to care for his daughter the way he felt he should and could have, which intertwines with intense self-criticism: he had blamed himself for not having noticed the warning signs, for not having insisted more with the doctors, for not being a "good enough father." Any experience of compassion or connection is blocked by guilt, self-criticism, and stagnant sadness, leaving him stuck in the same unchanging pain. Throughout the process, Mr. Y felt profoundly alone and misunderstood. He perceives that his partner, family, and social environment did not share his pain—for instance, when he saw that his mother did not keep any photos of his daughter. He also tended to isolate himself, ruminating about what happened, what he could have done, and the sadness of all the love he had to give, disappearing into the void of her absence. For Mr. Y, his daughter's death marked a before and after, leaving him trapped in a pain with no way out.

3.2.2 | Type 2: Vulnerable Without You—Unprotected and Unable to Function Alone ($n = 10$)

3.2.2.1 | General Description. In this type, the deceased provided a sense of safety and protection, experienced as the only figure who truly held the bereaved. Sometimes there were significant family problems—due to distance or conflict—or difficulties in various areas of life, and the deceased was perceived as an "oasis" of security, but also of love and validation. Although love or companionship may also be lost, the primary experience of this type was of lacking safety, dependency, and fragility in the absence of the other, which is what predominates. The bereaved may appear dissociated or disconnected from the world, alone and without a support network, or psychologically unable to function (displaying signs of psychological disorganisation) without the other. This could sometimes be linked to past trauma or longstanding difficulties (e.g., extreme parental neglect), and to psychological disorders (e.g., bipolar disorder).

The bereaved felt fragile without the other, and there was a degree of dependency. This may have stemmed from being left alone to face something overwhelming (e.g., parenting without a spouse), or from a dependent-fusional relationship (e.g., an adult daughter who had always lived with her mother), among other reasons. In some cases, the deceased had been a strong attachment figure, perhaps overprotective, and without him/her, the client felt exposed and vulnerable. At times, unfinished business related to other relationships surfaced—for instance, a man who lost his wife and felt helpless, echoing an earlier experience of abandonment by his parents. In any case, what is characteristic of this type is the fragility and the experience of being unable to function without the other person. The deceased usually functioned as a protective figure—or at least a source of "siblinghood" in the face of traumatic circumstances (e.g., siblings who supported each other during parental abuse).

What was most distinctive was that the client often had a sense of self based on fear and vulnerability—a feeling of fragility without the other. At times, emotions were experienced with great intensity leading to emotional flooding, collapse, and an inability to engage with their own experience. In line with this, there were difficulties in differentiating emotional states, a tendency to remain in secondary emotions (i.e., an emotion that arose as a reaction to another emotion and obscured the core emotion), such as hopelessness or undifferentiated and global distress, or even dissociation due to the intensity of the experience. A lack of agency (i.e., being a passive agent in relation to one's feelings) or emotional symbolisation was also common. The other had been the shield, the protector, or somehow had provided a sense of safety that was not found elsewhere and without him/her, the bereaved felt shaken and fragile. While these difficulties related to intense arousal and collapse were also found in Type 1 (*Shocked by the Death*), the difference was that in Type 1 they were more closely associated with the death itself, the trauma, and the pain, whereas in this case they were linked to dependency, a fused relationship, and the fragility and vulnerability experienced without the other. In this *Vulnerable Without You* type, the other person functioned as a regulatory figure, whereas in the previous type the nature of the death carried greater weight.

3.2.2.2 | Optimal Case. The optimal case for this type was Mrs. K. Mrs. K was a 53-year-old woman who had lost her mother after a prolonged illness with traumatic elements, both due to the illness itself and the death, which was related

to possible medical negligence. Mrs. K felt that her mother had been her only stable source of protection, and that her death had left her with an overwhelming sense of fragility and lack of safety in the face of life. From a young age, Mrs. K had taken on a protective role toward her mother in the context of an abusive father. This dynamic had persisted over the years, resulting in a mutually dependent relationship of care in which they both relied intensely on one another. For Mrs. K, the death represented not only the loss of the bond, but also the collapse of the emotional and functional structure that had sustained her life. In session, she could be observed collapsing (i.e., becoming unable to engage productively with her experience and feeling overwhelmed by despair and helplessness) in response to her mother's absence, and the sadness and fragility it evoked. Intense feelings of loneliness, fear, and abandonment emerged, along with a persistent state of emotional flooding and identification with her mother's pain. This experience was accompanied by symptoms of anxiety, agoraphobia, and somatisation, as well as significant difficulty in processing and regulating both sadness and anger. Even though the death had occurred more than ten years ago, Mrs. K still felt as though she couldn't live without her mother, and she continued to experience herself as a vulnerable child, lost in the woods.

3.2.3 | Type 3: The Lost Paradise—Loss That Cannot be Replaced ($n = 3$)

3.2.3.1 | General Description. In the third ideal type, which we named *The Lost Paradise,* the bereaved person's experience implied that without the loss of the deceased their life would be perfect. It included experiences such as: "With you, everything would be okay"; "I lost what could have been the perfect love"; or "If you hadn't died, all the problems that came afterward wouldn't have happened". The clients often focused on "why," but this was secondary to more core processes, such as self-criticism (e.g., "I'm defective") or unfinished business (e.g., related to bullying: "If you were alive, I would love myself, I wouldn't feel like I did in school when I felt awful."). While rumination might also have been present in other ideal types of complicated grief, what was defining here was the prominent use of fantasy as a means of regulating the pain of the loss. There was difficulty in tolerating the core emotional pain, and the person might have shown avoidance or a tendency toward narrative elaboration—consistent with a pattern of rumination or fantasy used to avoid emotional pain. At its core, this process was connected to unfinished business with some other person (e.g., shame) that had emerged with the death (e.g., a father neglecting his daughter after the mother's death), that had predated it (e.g., a longstanding loneliness before meeting the late ex-partner), or chronic emotional pain that persists in the present (e.g., intense current loneliness), all of which would not be felt in the presence of the other.

3.2.3.2 | Optimal Case. Mrs. J lost her father and her ex-partner in two separate car accidents. Although the loss of her father was painful and difficult, the grief she struggled most to process was the loss of her ex-boyfriend. When he died, they were no longer together and had been separated for a long time, but they remained friends and continued to see each other in a non-romantic way, partly due to his persistence. She often made excuses or rejected his invitations to meet, which led her to feel guilty, to criticise herself, and ultimately contributed partially to the complication of her grief. When her ex-boyfriend died, she realised what she had lost and began to idealise the relationship they had—and the one they could have had. She saw him as the perfect love/partner: caring, affectionate, attentive, loving. This idealisation pushed into the background other aspects, such as, as she described it, his insistence and his attempts to control her (e.g., asking her to say where she was, or with whom). She also seemed caught up in a kind of unproductive process, fantasising and ruminating over the future they would no longer share—possible children, a married life—all of which vanished with his death and her past rejections. However, this process was secondary and underpinned by more core—and even current—issues. Mrs. J was not in a relationship at the time of therapy, felt lonely, had not had healthy relationships in the past, and had a history of parental neglect and abuse. She had felt alone her whole life, and after her ex-boyfriend's death, even more so. In that emptiness, she found herself stuck, thinking about what could have been.

3.2.4 | Type 4: You Left Me All Alone—And Your Presence/Love Is Missing ($n = 3$)

3.2.4.1 | General Description. In the fourth ideal type (*You Left Me All Alone*), the deceased was perceived as the primary source of love, and without him/her, the person felt alone—without their refuge, without their love. This could be connected to unfinished business linked to loneliness involving others besides the deceased, which complicated the grieving process. For example, a daughter who, in the absence of her father (who was a source of love, comfort, and support), experienced the longstanding loneliness and sense of abandonment related to her mother. The difference from the previous type (*The Lost Paradise*) was that fantasy wasn't present or didn't constitute one of the main difficulties. Moreover, in the previous type, the core pain may have been primarily related to shame, loneliness, or fear. In contrast, in this type, the central difficulty concerned the experience of loneliness in the absence of the deceased.

This type of grief could be associated with both historical and present-day loneliness. Sometimes the experience took on different shades and wasn't limited to the loss of love, but also included the absence of support, understanding, or validation from the deceased—who tended to be idealised. Sadness was the predominant emotional experience, even more prominently than in other cases. There might have been other emotions, such as a certain fear in the absence of the other, but the primary emotion was sadness over the absence of the other related to the missing connection and love, which was not found in other current relationships. This emotion overshadowed other emotional experiences and was felt with great intensity. The client was usually able to symbolise the experience and did not tend to avoid it.

3.2.4.2 | Optimal Case. Mrs. N lost her mother at the age of 39. She was her primary attachment figure—someone with whom she felt seen, understood, loved, and deeply valued. After her death, Mrs. N described not only having lost her mother but also the only stable source of love and refuge in her life. She

missed her voice, her phone calls, her presence. She lacked this kind of relationship with her father and sisters—the rest of her nuclear family. They formed a close bond among themselves, leaving her feeling alone, misunderstood, and distant. It was not just the loss of love, but the absence of it elsewhere and the confrontation with that void. Grief brought her face-to-face with, or made more vivid and intense, the unfinished business with her father and sisters, and the loneliness connected to those relationships. It was a grief process rooted in pure loss, sadness, and loneliness.

3.2.5 | Type 5: Regret and Guilt Over Non-Action Pertaining to the Deceased—Triggering Core Shame and Self-Criticism ($n = 2$)

3.2.5.1 | General Description. In this ideal type, the bereaved might have criticised themselves for not having been present at the time of death or might have engaged in self-criticism in other related areas, including aspects of the relationship with the deceased (e.g., idealising the deceased while devaluing themselves). There was often a great deal of guilt and regret, but these were perhaps secondary to a deeper, more pervasive self-criticism that might have been present overall, not only in the context of the bereavement. This self-criticism was linked to a shame-based and self-contemptuous sense of self—experienced as unworthy and defective. This criticism was intense and core; it went beyond specific events and targeted the entire self, and wasn't merely a secondary process (as guilt) linke to grief-related sadness. The self-criticism might have been related to the death, but it appeared to have already been intense and chronic beforehand.

3.2.5.2 | Optimal Case. Mrs. U lost her husband after a progressive decline due to a neurodegenerative illness. During that time, she was her husband's primary caregiver, but after the death, her emotional experience became entirely entangled in intense self-criticism. She felt she wasn't there enough, that she was a bad wife. Guilt and regret were present, but they were subordinated to a deeper sense of shame, associated with a feeling of being intrinsically defective. Her experience was permeated by shame, self-contempt, and an internal critical voice from which she told herself that she was selfish, and even a "bad person." This criticism went beyond specific events: it was a global condemnation that overshadowed other emotional experiences, such as sadness or love, and appeared to act as a block to processing grief and accessing emotions like compassion or connection. This, combined with a tendency to withdraw from her experience and avoid emotional contact, left her grief process stuck.

3.2.6 | Type 6: The Death Prevents Any Chance of Resolution of Conflicts and Problems Prior to the Death ($n = 4$)

3.2.6.1 | General Description. Within this type, the complication was often linked to unfinished business with the deceased, involving experiences of neglect, lack of validation, criticism, or abandonment. In some cases, the bereaved had felt unprotected or unsupported in earlier life by the deceased, and the death intensified this longstanding sense of vulnerability, fear, and helplessness. In others, the deceased had been an important figure from whom the bereaved had expected recognition, but instead perceived an absence of validation, or even criticism. This often fed into self-criticism and guilt, sometimes heightened by specific circumstances surrounding the death (e.g., not having been present at the time of dying). In some cases, the deceased had been experienced as emotionally distant or unavailable, leaving the person with a deep sense of loneliness and unmet needs for love and connection. After the death, these experiences were felt as a more profound abandonment, with no possibility of repair. In any case, it was common for individuals to feel anger toward the deceased—an anger that obscured primary experiences, such as vulnerability.

Regardless of the nature of the prior unfinished business with the deceased, it seemed that the fact that the loss prevented any potential resolution (improvement in the relationship) hindered the mourning process as the opportunity to have a different experience (resolution) in real life was not available. These historical wounds tended to resurface during the dying process or after the death, sometimes due to the impossibility of reconciliation. Even when the relationship with the deceased had been conflicted, it was not entirely negative—complications may arise from unmet expectations and emotional needs that the mourner had hoped would be fulfilled, or because the deceased was experienced as intermittently responding to some of those needs, creating further ambivalence. However, grief also became complicated when the deceased was experienced as entirely negative or harmful. The complications stemmed from the damage that the bereaved attributed to the deceased or from the mourner's unmet hopes for something different, even from someone who had consistently caused harm. This often involved numerous unmet expectations and violated needs from the past. Although other factors may also have complicated their grief, these unresolved relational wounds appeared to be central.

3.2.6.2 | Optimal Case. Mrs. P lost her father suddenly while she was in another city. Although his illness had been prolonged, his death came as a shock, generating an emotional state that was difficult to process. Her father was an ambivalent figure for her: on one hand, her protector, her role model, someone who embodied stability and reason in a chaotic family; on the other hand, a controlling, critical man who never fully trusted her. During his life, their relationship had been marked by her ongoing struggle to gain his approval—validation that never truly came. However, the relationship was not entirely negative; there was also genuine care. For her, he was a central figure and source of protection. This ambivalence complicated the grieving process and the integration of the experience—of both sides of the relationship. Mrs. P's grief was not only for what she had lost, but also for what never fully came to be.

4 | Discussion

This study's findings align with previous research on grief, coinciding with what has been found regarding certain risk factors (Buur et al. 2024) or the incidence of certain problematic self-treatments, such as self-criticism in grief complications (O'Connor et al. 2015). However, it also offers a typology that

is new and different from other studies (e.g., Boelen et al. 2023). The typology of grief presented seeks to be phenomenologically rich and to facilitate an understanding of complications in the grief process, from which tailored interventions may be derived.

In our descriptive-interpretative results, one of the most frequent categories refers to a sense of vulnerability without the deceased person. This is consistent with what has been found in other studies that highlight anxiety in the attachment relationship with the deceased as a common characteristic in complications of the process (Smigelsky et al. 2019). In line with this, an ideal type of complicated grief presentation was identified (Type 2: *Vulnerable Without You*), which refers precisely to a kind of complication based on the mourner's experience of fragility. These individuals appear to be unable to function, either practically or psychologically, without the deceased and feel vulnerable or exposed to a world or a life that is perceived as overwhelming. The grieving process appears to be complicated due to the mourner's "need" for the other to function. Thus, the loss, in addition to being a profoundly sad experience, also threatens the self, leading to an unresolved sense of vulnerability without the other. The therapeutic work in this complication in which the client is unable to function without the deceased may mean also working with the fragility that, in many cases, predates the death. Until a certain individuation is achieved, or the experience of weakness is transformed into something akin to strength, the grief cannot be fully processed.

Related to these findings, we observed that most relationships were experienced as predominantly positive. In such cases, grief seems more likely to be linked to something positive or helpful to functioning in the world being lost. Nonetheless, there can also be positive relationships and fragility that do not necessarily precede the death but rather emerge from the death itself. This is the case of Type 1: *Broken/Shocked By The Death*. This type of difficulty establishes death as a trauma (a relationship previously explored in grief: O'Connor et al. 2015), in response to which the mourner feels pained, in shock, and with a deep sense of fragility, experiencing these emotions with high intensity. In such cases, grief intervention must address these traumatic experiences and the experience of fragility, pain, and fear directly.

We also observed that when someone is lost, multiple dimensions that were present—or expected to be present—in the relationship are also lost. Thus, working through grief may involve addressing the loss in all its dimensions—that is, grieving the future: what is lost, what never came to be but was expected, and is now rendered even more impossible by death (e.g., a hug that never happened). Sometimes it feels as though, in losing the other, everything—or something essential—is lost, such as the possibility of being well. It may well be that there is some idealisation present, as observed in other studies (Hayes 2016), and the fantasy of another or a perfect world may function as a way to regulate the pain. In such cases, it is important to understand the function of the "fantasy" as a regulator of pain and to address this alongside the avoided experiences.

Additionally, problematic self-treatment, such as self-criticism or interruption (avoidance) of own emotional experiences, was also observed. The role of guilt and criticism has been highlighted in the grief literature (Levi-Belz and Blank 2023) and was identified as a type in our study (Type 5: *Regret and Guilt Over Non-Action Pertaining To The Deceased*). As we see in this type, the core experience of the self as defective, bad, or ultimately negative is one of the most meaningful and central aspects of the complicated grief process. This complicates grief processing because it obscures other experiences, such as sadness, and directly hinders the experience of connection and compassion that would promote resolution of the grief (Gamoneda et al. 2026). Therefore, addressing and transforming self-criticism and the core experience of shame is essential to process the loss.

In the case of emotional interruption, avoidance was usually not very intense or at the point of completely blocking emotion during the session, but rather related to experiences outside of sessions or at specific moments during the session. Emotional avoidance contributes to difficulties in processing the loss as no emotions (including grieving) are being processed when blocked. While it is true that the grief literature has identified prior psychopathology, symptoms and their intensity, and certain secondary emotions such as anxiety and depression (Buur et al. 2024; Gil-Juliá et al. 2008), or emotional avoidance (Eisma and Stroebe 2021), as risk factors, it is less common to find the role of emotional processing discussed in a structured and coherent manner. We would like to highlight that it is how the mourner approaches and experiences their emotions that facilitates contact with the emotional experience, including grieving, and meaning-making process.

We also observed that our mourners perceived a lack of social support, a space to grieve, and experiencing loneliness, a risk factor historically recognised in the grief literature (Gil-Juliá et al. 2008). Sometimes this loneliness is related to a historical feeling connected to the deceased, or to other people in the present or past who are different from the deceased. For instance, in one case, the death of an affectionate mother led her son to experience more fully and painfully not only this relational loss but also the historical loneliness connected to his father. This complicates the grief because accepting the death implies opening up to an intense loneliness that was perhaps not attended to for some time or was avoided as it was too painful. In such cases, the clinician may need to address this unfinished business and transform chronic loneliness through tasks such as the empty-chair task (Gamoneda et al. 2026), in order to facilitate the grieving process.

We observed that when the relationship was predominantly negative what appeared to be complicating the grieving process were the unresolved matters and conflicts with the deceased, which were related to chronic emotions such as loneliness, fear, or shame. In such cases, these long-standing emotions connected to the relationship seemed to require therapeutic attention in order to facilitate adaptive experiences, such as sadness, as they acted as blocks to these experiences and to the grieving process itself (Gamoneda et al. 2026). They also complicated grief further by fostering ambivalence and contradictory feelings toward the deceased, such as anger and love.

However, complications are not solely related to pre-existing vulnerability, the relationship with the deceased, or emotional processing difficulties. At times, the grief complications extend

beyond the mourner or their relationship with the deceased and involve economic and social challenges, which act as stressors hindering the grief process (Buur et al. 2024). In some ways, this may force the mourner to focus on essential life issues unrelated to the loss, thus relegating the loss to the background, leaving it frozen in time, or, as Middleton et al. (1996) describe it, delayed. Nonetheless, the social and economic stressors may also complicate grief by adding complexity and suffering to the person's life situation.

Our observations suggest that when complicated grief is present, it is necessary to address what complicates the grieving (e.g., prior conflicts with the deceased). We would like to stress that what matters is identifying which processes are important to work on therapeutically. Accordingly, the clinician should address the primary difficulty (e.g., self-criticism) in a manner that is process-appropriate (e.g., transforming the associated criticism and shame) in order to unblock the grieving process. In addition, this work should be complemented by interventions that cut across grief presentations, such as addressing loss-related sadness (Gamoneda et al. 2026), thereby attending both to the differential processes that complicate grief and to the general processes that need to be considered across cases. Therefore, types and categories should serve to enrich individualised case formulations, from which specific interventions are subsequently derived, rather than functioning as ends in themselves. By providing concrete and descriptively rich information, clinicians can draw on different strategies to address these difficulties. In this way, the classification can be useful not only for EFT or humanistic therapists, but for any clinician working with grief. Moreover, it can be incorporated into the training of therapists and other professionals across different services, helping them to identify whether complications are present, what they look like, and how they might be addressed.

One has to bear in mind that the ideal types we proposed here focus on the differences in grieving; however, in reality, most people will experience the type of complications in grieving that would cross several of the presented ideal types as documented in our descriptive-interpretative analysis. It is important to notice that, as with any classification concerning aspects of human life, when applied rigidly it can be problematic. Clinicians should therefore understand this framework as heuristic, intended to support the organisation and understanding of clinical knowledge and to inform intervention, rather than prioritising categories over the person and what unfolds in the session.

5 | Limitations

There are several limitations that the reader of this paper should bear in mind. One of the main limitations is the sample size ($N = 26$), which makes it difficult to reach saturation in terms of types and categories representing potential complications in the grieving process. Another limitation concerns the gender distribution of the sample (25 women and one man), together with a degree of cultural homogeneity (primarily Spain and Latin America), which may limit the generalisability of the findings. Thus, it is recommended to test these types in broader and more heterogeneous samples, remaining sensitive to the possible emergence of additional types. An additional consideration is related to the theoretical orientation of the researchers, rooted in the understandings of EFT, which influences the lens through which the data are viewed and interpreted. In future studies, it would be advisable to triangulate the analyses with external auditors who are not affiliated with the EFT model, or to incorporate additional strategies, such as the use of a reflexivity journal.

6 | Conclusion

In descriptions of complications in grief, research has typically focused on risk factors or categories of complication (Buur et al. 2024; Gil-Juliá et al. 2008), or on models that offer an overarching view of grief and its complications (e.g., Stroebe and Schut 1999). Overall, the literature includes more general models that are more distant from lived experience. Our classification aims to add a more comprehensive description that occupies an intermediate position between these two extremes: it is grounded in the bereaved person's direct experience, describes rich phenomenological experiences (e.g., experiences of fragility), and organises them into broader types or descriptions that allow for a coherent, descriptive, and in-depth narrative. In this way, it does not merely account for isolated categories or, conversely, overly general explanations, but rather for complications that can meaningfully explain the specific case encountered in therapy.

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Ethics Statement

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee. This study was approved by the Ethics Committee of the Universidad Pontificia Comillas (issuance report number 14122020).

Consent

Written informed consent was obtained from all participants prior to data collection.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The datasets generated during and/or analysed during the current study are available from the corresponding author on reasonable request.

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