RUNNING HEAD: PCBRD IN DSM-5

Commentary on the Inclusion of Persistent Complex Bereavement-Related Disorder in DSM-5

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In Press with Death Studies

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Accepted for publication: June 23, 2012

Abstract

The DSM-5 Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group has proposed criteria for Persistent Complex Bereavement-Related Disorder (PCBRD) for inclusion in the appendix of DSM-5. We, the present authors, feel that it is important that dysfunctional grief will become a formal condition in DSM-5 because that would facilitate research and would imply recognition of the suffering of a significant minority of bereaved individuals who experience difficulties in their process of recovery from loss. However, as detailed in this commentary, we oppose the inclusion of the proposed criteria-set for PCBRD for several reasons, including the fact that these criteria lack empirical evidence. In our view, it is better to include empirically validated criteria for Prolonged Grief Disorder in DSM-5, possibly expanded with a few symptom-criteria that are tapped by the Inventory of Complicated Grief, the most widely used instrument to measure dysfunctional grief.

Keywords: Prolonged-Grief-Disorder; Complicated-Grief; DSM-5; Persistent-Complex-Bereavement-Related- Disorder; Adjustment-Disorder

Commentary on the Inclusion of Persistent Complex Bereavement-Related Disorder in DSM-5

There is growing recognition among scholars and clinicians that, after the death of a loved one, a significant minority of people develop persistent and debilitating symptoms of grief. In the mid-1990s, Prigerson, Frank et al. (1995) identified a set of grief-specific symptoms and found that these symptoms, of what was then termed Complicated Grief, were distinct from symptoms of depression and predicted later health impairments above and beyond concomitant depression. Numerous studies throughout the world have replicated and expanded these findings. There is now strong evidence that there is a set of grief symptoms that forms a unitary dimension, distinct from symptoms of depression, posttraumatic stress disorder (PTSD) and other anxiety disorders that is associated with severe distress and disability, even when controlling for co-occurring symptoms of depressive and anxiety disorders (Boelen & Prigerson, in press; Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 2009; Shear et al., 2011).

DSM-5

Based on these findings, it has been stressed that this condition of dysfunctional grief meets the definition of a mental/psychiatric disorder as put forth by Stein et al. (2010) and, as such, should be included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Accordingly, the DSM-5 has agreed that a disorder of grief should be included. The current state of affairs (June 2012) is that the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group has proposed the addition of a subtype of Adjustment Disorder, called *Adjustment Disorder Related to Bereavement*, placed in the main body of the DSM-5 (APA, 2012a). In addition, criteria for *Persistent Complex Bereavement-Related Disorder* (PCBRD) have been proposed for

inclusion in Section III where conditions that require further research will be placed (APA, 2012b).

Adjustment Disorder Related to Bereavement is defined as present when "Following the death of a close family member or close friend, the individual experiences on more days than not intense yearning or longing for the deceased, intense sorrow and emotional pain, or preoccupation with the deceased or the circumstances of the death for at least 12 months (or 6 months for children)." The criteria also described that "The person may also experience difficulty accepting the death, intense anger over the loss, a diminished sense of self, a feeling that life is empty, or difficulty planning for the future or engaging in activities or relationships." To meet criteria for caseness of *Adjustment Disorder Related to Bereavement* symptoms should cause "marked distress that is in excess of what would be proportionate to the stressor" and/or "significant impairment in social, occupational, or other important areas of functioning" (APA, 2012a). The addition of this Adjustment Disorder subtype appears to us to be progress over the way disabling grief has thus far been addressed in DSM. However, what is problematic is that, taken strictly, a person can already qualify for this disorder if s/he experiences one of the symptoms listed at ≥12 months post-loss to a distressing and disabling the degree, which likely increases rates of false positive diagnoses (cf. Wakefield, 2012). It is also not clear why two grief-specific diagnoses should be included in DSM-5. Furthermore, Adjustment Disorder Related to Bereavement has all the problems that are also associated with the more demanding criteria proposed for PCBRD, including a lack of empirical evidence for its validity.

PCBRD is defined as present when the person meets each of the five criteria listed in Table 1. Criterion A requires that the individual experienced the death of a close family member or close friend at least 12 months ago. Criterion B prescribes that the person should experience at least one of four symptoms of what seemingly represents separation distress

(although symptoms are not explicitly referred to as such). To meet criterion C, at least six symptoms must be present from a list of 12 symptoms. These 12 symptoms are categorized into six symptoms of *Reactive Distress to the Death* (e.g., feeling shocked/stunned/ numb, difficulty with positive reminiscing) and six symptoms of *Social/Identity Disruption* (e.g., a desire to die, feeling alone or detached from others). PCBRD "caseness" requires that the symptoms cause distress and impairment in functioning (Criterion D) and that these are "out of proportion or inconsistent with cultural, religious, or age-appropriate norms" (Criterion E). A specification can be made for PCBRD *with Traumatic Bereavement* requiring that the death occurred under traumatic circumstances (e.g. homicide, suicide, disaster, or accident) and reactions include intrusive thoughts and feelings. This specification seems unnecessary and unhelpful. It suggests that, rather than increasing the risk for PCBRD and possibly comorbid PTSD, traumatic losses can give rise to a third category of dysfunctional grief that represents a mixture of PCBRD and PTSD.

Criteria-sets for Adjustment Disorder Related to Bereavement and PCBRD overlap considerably, but differ in that PCBRD includes a specified list of 12 symptoms—not all of which are listed as symptoms of Adjustment Disorder Related to Bereavement—and specifies that six of these 12 symptoms must be present. Below, we will argue that the proposal for PCBRD is problematic because it is not based on empirical evidence, dismisses evidence supporting other criteria, and endangers progress made in understanding the nature of dysfunctional grief.[1]

Add Table 1 About Here

Clever Compromise or Sacrificial Satisficing?

[1] The application of PCBRD-criteria to dysfunctional grief among children and adolescents is very important but not discussed in this commentary.

The proposal for PCBRD seems to be a compromise of two other criteria-sets, namely empirically validated criteria for Prolonged Grief Disorder proposed by Prigerson and coauthors in 2009, and criteria for Complicated Grief recommended by Shear and coauthors in 2011. (All three criteria-sets are shown in Table 1.) The *naming* of PCBRD seems to be a compromise in that the terms Prolonged and Complicated seem to have been turned into Persistent and Complex, respectively. More importantly, *symptom-criteria* of PCBRD are a compromise, in that they include symptoms from both criteria-sets, expanded with a few new symptoms. Specifically, the PCBRD criteria "yearning/longing" (B1), "difficulty accepting the death" (C1), "feeling shocked/stunned/numb" (C2), "bitterness/anger" (C4), "avoidance" (C6), "difficulty trusting other people" (C8), "feeling that life is empty/meaningless" (C10) are all included in both these two other criteria-sets. Other criteria are from one of both criteria-sets. That is, the PCBRD criterion "confusion about one's role in life" (C11) is from the Prolonged Grief Disorder criteria, and the PCBRD criteria "desire not to live" (C7) and "feeling alone" (C9) seem to have been taken from Shear et al's proposal. Other symptoms of PCBRD criteria are new. For instance, the timing criterion (symptoms present after ≥12 months post-loss) differs from the ≥6 months post-loss timing criterion proposed in both these prior sets. In addition, the criteria "difficulty in positive reminiscing" (B3) and "maladaptive appraisals about oneself" (B5) were not included in the sets proposed by Prigerson et al. (2009) and Shear et al. (2011).

Criteria for PCBRD: A Critical Appraisal

There are several interrelated concerns about the criteria for PCBRD.

Lack of Evidence

First and most importantly, empirical evidence that PCBRD criteria are reliable and valid are lacking. For instance, there is no evidence that the ≥12 months post-loss timing criterion effectively and/or efficiently distinguishes between people who do versus people

who do not recover from their loss. In fact, several studies that have examined the time course of dysfunctional grief reactions have suggested that, if present, these symptoms hardly decrease beyond six months post-loss and that, assessed at six months but not two or three months post-loss, these symptoms predict adverse mental and physical health outcomes later in time (Prigerson et al., 1997, 2009; Prigerson, Frank et al., 1995). Consequently, holding on to this ≥12 months timing criterion could inflate the rate of missed cases of dysfunctional grief. Moreover, this ≥12 months specifier would delay the provision of treatment for all those who already suffer considerably at six months post-loss.

Second, no evidence exists that symptoms from Criterion C of PCBRD represent distinguishable factors of *Reactive Distress* and *Social/Identity Disruption*. Research has repeatedly shown that symptoms of Prolonged Grief Disorder/Complicated Grief, several of which are categorized under Criterion C for PCBRD, form a unitary cluster of symptoms (Boelen & Hoijtink, 2009; Newson, Boelen, Hek, Hofman, & Tiemeier 2011; Prigerson et al., 2009). The few studies that did find evidence for multidimensionality came up with different factors than the ones proposed in the PCBRD criteria (e.g., Holland & Neimeyer, 2011; Simon et al., 2011).[2] Moreover, this distinction has little face validity. For instance, it is unclear why "maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)" are categorized as *Reactive Distress* and not *Social/Identity Disruption* given the linkage of these appraisals with self-identity.

Third, there is no evidence that some of the new PCBRD criteria (criteria not previously proposed by Prigerson et al. [2009] or Shear et al. [2011]) are valid markers of dysfunctional grief. For instance, positive reminiscing is an aspect of healthy grief (cf.

[2] In Simon et al.'s (2011) analyses, that Shear et al.'s (2011) criteria for Complicated Grief draw on, it was only in a factor analysis with data from a subsample of identified cases of Complicated Grief that subfactors emerged. In the full sample, including cases and noncases of Complicated Grief, symptoms of Complicated Grief formed a unitary factor.

Bonanno, 2004). Yet, there is no evidence that "difficulty in positive reminiscing about the deceased" (PCBRD Criterion B3) is a putative marker of dysfunctional grief. Quite the contrary appears to be true: positive reminiscing can become a ruminative fixation that serves to avoid thoughts about the irreversibility of the loss that seem too painful to bear (Stroebe et al., 2007). As a further example, evidence is also lacking that "maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)" (PCBRD Criterion C5) is a good marker of dysfunctional grief. Cross-sectional and prospective studies have shown that negative self-appraisals following loss are more strongly associated with depression than with dysfunctional grief (Boelen & Lensvelt-Mulders, 2005; Boelen, Van den Bout, & Van den Hout, 2006). There is also no evidence that self-blame is associated with dysfunctional grief (Field, Bonanno, Williams, & Horowitz, 2001; Golden & Dalgleish, 2012). Notable also is that evidence exists that "a desire not to live in order to be with the deceased" (PCBRD Criterion C7) is a serious *consequence* of dysfunctional grief (Latham & Prigerson, 2004), but there is no evidence that this is also a valid criterion or integral feature of this condition.

A fourth example of lack of evidence, is that no evidence is yet available that supports the operating characteristics of the PCBRD criteria. That is, we do not yet know whether one out of four symptoms listed under Criterion B, and six out of twelve symptoms listed under Criterion C, provides the best distinction between cases and non-cases.

Extreme Heterogeneity

This brings us to a second concern. That is, the algorithm for PCBRD caseness yields 37,650 possible combinations in which a person could qualify for the diagnosis.[3] This is in stark contrast with Shear et al.'s (2011) proposed criteria for Complicated Grief. With a one out of four symptoms requirement for Criterion B, and a two out of eight symptoms

[3] Calculations are based on combinatorics.

requirement for criterion C, that set yields "only" 3,705 possible combinations.[4] It is even in sharper contrast with Prigerson et al.'s (2009) criteria-set for Prolonged Grief Disorder. This set, requiring five of nine symptom-criteria listed under Criterion C to be present, has a relatively small number of 256 possible combinations.

Thus, PCBRD is an extremely heterogeneous construct. Its inclusion in DSM-5 poses the risk of moving the field backward, from the increasingly clear description of problematic grief as a combination of 10 to 15 symptoms present to the point of impairment (cf. Horowitz et al., 1993, 1997; Prigerson et al., 1999; 2009), back to the days where numerous combinations of numerous symptoms were used to define numerous different "disorders of grief", including morbid, absent, delayed, inhibited, distorted, conflicted, unanticipated, and chronic grief (cf. Parkes & Weiss, 1983; Rando, 1993). Moreover, adding this heterogonous construct to DSM-5 would inadvertently suggest to clinicians and researchers alike that we have learned very little about what constitutes dysfunctional grief since the mid-1990s.

Distinction from Normal Grief

A further problem associated with this heterogeneity of PCBRD is that some of the criteria are likely quite easily met. For instance, the one out of four symptoms requirement for Criterion B likely will be easily met because Criterion B2 ("Intense sorrow and emotional pain because of the death") is so broadly defined that many bereaved persons will meet this criterion. Even beyond 12 months post-loss this "intense sorrow and pain", but also other symptoms such as "difficulty in positively reminiscing" (Criterion C3) and "feeling alone" (Criterion C9), perhaps seem better categorized as components of "normal" rather than disturbed grief.

[4] In Table 3 of Shear et al's (2011) paper, nine symptoms are listed under Criterion C. Given that the ninth symptom ("Disturbing emotional or physiological reactivity to reminders of the loss") is almost identical to Criterion C7 ("Experiencing intense emotional or physiological reactivity to memories of the person who died or to reminders of the loss") and is not listed in Table 2, this is likely an unfortunate error.

Researchers who have pleaded for the inclusion of dysfunctional grief in DSM have sometimes been said to medicalize and pathologize normal grief (Collier, 2011; The Lancet, 2012; Wakefield, 2012). These concerns can be allayed. Never, for instance, have proponents of including dysfunctional grief in DSM (Horowitz et al., 1993, 1997; Prigerson et al., 1999; 2009; Shear et al., 2011) pleaded for "making grief an illness" (Collier, 2011, p. E440) or denied that "grief is not an illness" (The Lancet, 2012, p. 589). Stein et al. (2010) noted that a syndrome included in DSM-5 should "not merely [be] an expectable response to common stressors". It is well recognized, based on the work of Bonanno and others (2002, Bonanno, 2004) that *resilience* and not chronic grief is the "expectable response" to bereavement. Therefore, we do not have to worry that a majority of people now suddenly will be diagnosed with a mental illness—at least no more than that we have to worry that, for instance, transient low mood is falsely diagnosed as signaling major depression. There is also no empirical evidence that inclusion of dysfunctional grief in DSM-5 will lead bereaved people to seek help in the "private office of psychotherapists" at the expense of seeking help in their own communities (Collier, 2011, p. E440). Nevertheless, it is important to take concerns about pathologization and stigmatization seriously and, therefore, to avoid the inclusion of signs of normal grief among the standardized criteria.[5]

[5] The distinction between dysfunctional and normal grief is complex. There is evidence that these concepts are better described as two extremes of a single dimension rather than as being categorically distinct (Holland, Neimeyer, Boelen, & Prigerson, 2009). However, at the same time, Wakefield's (2012) conclusion that "there is no clear qualitative difference between PGD symptoms and normal grief" (p. 503) seems overstated. For instance, there are two studies by Boelen and Van den Bout (2008) and by Dillen, Fontaine, Verhofstadt-Denève (2008), respectively, in which symptoms of dysfunctional grief tapped by the Inventory of Complicated Grief (Prigerson, Maciejewski et al., 1995) and scores on items from the Texas Revised Inventory of Grief (TRIG; Faschingbauer et al., 1987), a measure tapping benign grief reactions (e.g., crying) loaded on distinct factors in confirmatory factor analyses. Noteworthy also is that in studies by Boelen et al. (2003) and Prigerson, Maciejewski et al. (1995) scores on the Inventory of Complicated Grief were more strongly associated with quality of life impairments than were scores on the TRIG and that in Boelen et al.'s (2007) treatment study, symptoms tapped by the Inventory of Complicated Grief but not those tapped by the TRIG decreased over the

Discontinuity in Clinical Practice and Research

Another problem with criteria for PCBRD is that their inclusion in DSM-5 could cause a significant discontinuity in clinical practice and research. To the extent that clinicians have become accustomed to the way in which Prolonged Grief Disorder or Complicated Grief has been defined in the past 15 to 20 years, they now have to get acquainted with a new description of dysfunctional grief. One could say that, because criteria have already changed over the years (e.g., compare sets proposed by Prigerson et al. in 1999 vs. 2009), adding this novel criteria-set is not really a problem. However, several aspects of the PCBRD criteria, including the ≥12 months time criterion and the inclusion of normal (i.e., "intense sorrow and pain") and new symptoms (e.g., "suicidality"), differ greatly from criteria-sets proposed previously. Therefore, their inclusion in DSM-5 will cause at least some discontinuity in usual clinical decision making for clinicians working with bereaved patients. At worst, the divergence of PCBRD-criteria from more well-known descriptions of dysfunctional grief could undermine their acceptability and lead to their nonuse.

In addition, new diagnostic instruments to assess PCBRD have to be developed to inform clinical work. Currently, the Inventory of Complicated Grief (Prigerson, Maciejewski et al., 1995) is one of the most widely used instruments to assess dysfunctional grief with 423 citations for the Prigerson, Maciejewski (1995) paper as per June 2012 and over 20,000 bereaved individuals worldwide to whom it has been administered (Maciejewski, personal communication, based on a summary of published data using this instrument). Because different symptoms of PCBRD are not included in the Inventory of Complicated Grief, the instrument likely will become much less useful in clinical practice than it is now.[6] As a result,

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course of cognitive behavioral treatment. These findings, not included in Wakefield's (2012) discussion, suggest that grief-reactions differ in their performance as markers of dysfunctional grief.

[6] A 34-item extended version of the 19-item Inventory of Complicated Grief was published in 2001 (Prigerson & Jacobs, 2001). However, the 19-item version has been used most frequently. Pertinent to the present commentary

advances based on the use of a standardized metric for dysfunctional grief will register major setbacks.

Inclusion of PCBRD can also cause a discontinuity in research. The Inventory of Complicated Grief has been used in the majority of studies that have investigated prevalence-rates (e.g., Forstmeier & Maercker, 2007; Morina, Von Lersner, & Prigerson, 2011; Newsom et al., 2011), biopsychosocial correlates and risk factors (Burke & Neimeyer, 2012; Lobb et al., 2010; Van der Houwen et al., 2010), and treatment interventions (Boelen, De Keijser, Van den Bout, & Van den Hout, 2007; De Groot et al., 2007; Holland, Currier, & Gallagher-Thompson, 2009; Shear, Frank, Houck, & Reynolds, 2005) for dysfunctional grief. Inclusion of PCBRD-criteria to DSM-5 means that none of the research findings regarding the prevalence, risk factors, and treatment of dysfunctional grief are directly applicable to this new disorder. This will confuse clinicians' efforts to integrate these prior research findings about Prolonged Grief Disorder/Complicated Grief into their clinical practice and will considerably complicate the possibility for researchers to integrate these prior findings with new data obtained using the PCBRD-criteria (cf. First et al., 2004).

Are There Solutions?

What solutions exist to the problems with PCBRD outlined above?

Exclude Any Disorder of Grief from DSM-5

A first solution is not to include any specific disorder of grief in DSM-5. Indeed, one could argue that because of the controversies and unresolved issues surrounding the proposed inclusion of a specific disorder of grief, it is better to postpone inclusion. However, by doing so, we would neglect compelling evidence that dysfunctional grief meets criteria for a mental/psychiatric disorder, as recently put forth by Stein et al. (2010). That is, the condition constitutes a clearly identifiable and recognizable cluster of symptoms, one that can be

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is that the 34-item version does not include the PCBRD symptoms that were not previously proposed as defining features of dysfunctional grief.

reliably assessed and distinguished from its nearest neighbors (including major depressive disorder and PTSD), is associated with clinically significant distress or disability, is not an expectable response to a common stressor, and has diagnostic validity and clinical utility (Boelen & Prigerson, in press; Lichtenthal et al., 2004; Prigerson et al., 2009; Shear et al., 2011).[7] Furthermore, as noted, keeping the condition outside DSM-5 would unwittingly suggest that we have learned very little about what constitutes dysfunctional grief.

Include Existing Criteria-Sets

A second solution could be to choose one of the three criteria-sets that have received most attention in the literature, i.e., criteria for Complicated Grief Disorder proposed by Horowitiz et al. (1993, 1997), criteria for Prolonged Grief Disorder (Prigerson et al., 2009), or criteria for Complicated Grief (Shear et al., 2011). The first set has been utilized in several studies (see, e.g., Forstmeier & Maercker, 2007). However, no studies have systematically tested the incremental validity of these criteria and their distinctiveness from depression, PTSD, or other DSM-neighbors. Furthermore, Horowitz and Prigerson together endorsed the criteria for Prolonged Grief Disorder (Prigerson et al., 2009) as the updated version of Horowitz' prior criteria-sets.

Adding Shear et al.'s (2011) criteria for Complicated Grief to DSM-5 would be premature, because the incremental validity and distinctiveness of these criteria also have not yet been tested. In fact, at this moment, these criteria have a rather modest empirical basis. For instance, although these criteria were informed by a series of statistical analyses (Simon et al., 2011), it is not clear how exactly the item response theory analyses, factor analyses, and sensitivity/specificity analyses conducted by Simon et al.(2011) were linked with the final criteria proposed by Shear et al. (2011). For instance, all analyses conducted by Simon et al.

[7] Even Wakefield (2012) who recently described his reservations about inclusion of dysfunctional grief in DSM-5 stated that "there are individuals who do experience interminable intense grieving and are indeed disordered" (p. 506), rightfully adding that "this is likely a very small group" (p. 506).

(2011) were done using items from the 19-item Inventory of Complicated Grief (Prigerson, Maciejewski et al., 1995). However, some of the criteria included in the final set (e.g., Criterion C1, "troubling rumination" and Criterion C7 "emotional/physiological reactivity", see Table 1) are not tapped by this measure. Consequently, the reliability and validity of some of the individual criteria, as well as the operating characteristics of the combination of criteria still need to be investigated. A further concern is that some of the Complicated Grief criteria are quite broadly formulated. For instance, Criterion B3 (Table 1) actually includes four symptoms, namely recurrent thoughts that it is (i) *unfair*, (ii) *meaningless*, or (iii) *unbearable* to have to live, or (iv) *a recurrent urge to die* in order to find or to join the deceased. Thus, there are already 15 ways a person can meet this single criterion. This seems problematic given that there are already 3,705 ways to qualify for the Complicated Grief diagnosis. Notable too is that some of the symptom-criteria, including the "identificatory" and "hallucinatory" symptoms included in Criterion C6 ("Frequently experiencing pain or other symptoms that the deceased person had, or hearing the voice or seeing the deceased") have been found to be poor markers of dysfunctional grief in prior studies (Boelen & Hoijtink, 2009; Newson et al., 2011; Prigerson et al., 1999), whereas the performance of other individual symptoms such as rumination and suicidality has not been examined at all. Moreover, it is troubling that the majority of the sample (i.e., 73%) from which the criteria were derived had at least one secondary diagnosis. Deriving criteria for Complicated Grief from such a mixed sample seems akin to an analysis that would attempt to derive the elements of the color yellow from the color brown. In contrast, the Prigerson et al. (2009) criteria were "purified" to distill components of what constituted Prolonged Grief Disorder and then those who met criteria were examined for comorbidity with other "pure" or independent, distinct disorders such as Major Depressive Disorder.

This is one of the reasons why, in our view, the DSM-committee should consider adding the Prolonged Grief Disorder criteria to DSM-5 (see Table 1). A significant strength of this proposal is that it was informed by a series of transparent empirical analyses that successively focused on (i) identification of unbiased and informative markers of Prolonged Grief Disorder with methods from item response theory modeling, (ii) determination of a criterion standard for caseness, (iii) determination of the most parsimonious combination of symptoms that best distinguished between cases and non-cases of Prolonged Grief Disorder, (iv) comparison of the validity of *acute* Prolonged Grief Disorder (meeting criteria for caseness at 0-6 months but not at 6-12 months), *delayed* Prolonged Grief Disorder (caseness at 6-12 months but not 0-6 months), and *persistent* Prolonged Grief Disorder (caseness at 0-6 months *and* 6-12 months) in order to inform the timing criterion (that was set at ≥6 based on these analyses), and (v) confirmation that Prolonged Grief Disorder caseness at 6-12 months post-loss predicted adverse health outcomes at 12-24 months post-loss beyond concomitant depression, posttraumatic stress, and generalized anxiety—attesting to the set's incremental validity.[8] A further strength of the Prigerson et al. (2009) criteria is that they represent the culmination of a sizeable and still growing body of evidence showing that the very symptoms that are at the heart of Prolonged Grief Disorder (i.e., its ten symptoms listed under Criterion B and Criterion C, see Table 1) are part of a single dimension of distress, one that is distinct from other DSM-categories, predicts health impairments, has specific biopsychosocial correlates, and is responsive to specific treatment interventions designed to target dysfunctional grief (Boelen & Prigerson, in press; Lichtenthal et al., 2004).

[8] In discussing Prigerson et al.'s (2009) analyses, Wakefield (2012) recently mistakenly noted that in the analyses focused on the predictive validity of Prolonged Grief Disorder, caseness was "defined simply as being among the most severe 20% at 6- to 12-month evaluation" (p. 507). This is not correct; in these analyses Prolonged Grief Disorder cases were defined as those meeting criteria formulated in steps 1 through 4 of the analyses.

More work is obviously needed to test these criteria. For instance, the analyses informing the Prolonged Grief Disorder criteria primarily (although not exclusively) relied on data from older, white, conjugally bereaved subjects. Although this is a group likely to be stricken by dysfunctional grief and thus quite an appropriate group to develop and test standardized criteria, the performance of criteria in other groups still needs to be assessed. That notwithstanding, the empirical basis of criteria for Prolonged Grief Disorder seems considerably stronger than the empirical basis of PCBRD and Shear et al.'s (2011) proposal for Complicated Grief.

Choosing Symptom-Criteria That Have Been Put to the Test

This brings us to a third and related possible solution for the problems associated with the PCBRD proposal. This solution could be to keep the symptom-criteria for a new DSM-5 condition of dysfunctional grief limited to symptoms that are tapped by the Inventory of Complicated Grief (Prigerson, Maciejewski et al., 1995). This would mean that symptoms not included in this instrument (e.g., "difficulty in positively reminiscing about the deceased", "maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)", "a desire not to live in order to be with the deceased" from the PBCBR-criteria, and "troubling rumination" and "emotional/physiological reactivity" from the Complicated Grief-criteria) would not be included in such formal, standardized criteria. As noted, most studies on dysfunctional grief used the Inventory of Complicated Grief. Therefore, choosing symptom-criteria from the symptoms tapped by this measure would enable researchers to conduct reanalyses of the many datasets that have been collected with this scale, among many different bereaved groups, from many different cultures, in many different countries, by many different research groups. Such reanalyses could focus on issues such as the optimal timing criterion and the ability of different combinations of symptoms to reliably distinguish cases from noncases. Reanalyses of existing data could also enhance knowledge about the

delineation of the condition from other syndromes and its demographic, biological, psychological correlates (data pertinent to these issues have been gathered in many prior studies). If PCBRD (but also its milder counterpart of *Adjustment Disorder Related to Bereavement*) would be included in DSM-5, collection of data to examine these issues would have to start all over again. Stated differently, the process of iteratively improving DSM-criteria for dysfunctional grief could *jump-start* if symptom-criteria included would all be chosen from the Inventory of Complicated Grief and would *start from scratch* if criteria now proposed for PCBRD were included.

We recognize that, if this option were chosen and symptom-criteria were selected from the Inventory of Complicated Grief, this DSM-condition likely would resemble Prigerson et al.'s (2009) criteria-set for Prolonged Grief Disorder more than Shear et al's (2011) proposal for Complicated Grief. In fact, it will not be surprising to readers that we, the current authors, see many advantages in choosing this option. However, this option does leave room to expand the list of ten symptom-criteria that are now included in the criteria for Prolonged Grief Disorder (see Table 1). For instance, if supported by clinical observations and empirical studies, consideration could be given to adding "preoccupation with thoughts of the deceased", "preoccupation with memories associated with the loss", and "feeling drawn to places associated with the deceased" to the ten symptoms now listed as symptom-criteria of Prolonged Grief Disorder. Inclusion of these particular items seems justified given that they emerged as unbiased and informative items in prior (item response theory) analyses (Boelen & Hoijtink, 2009; Prigerson et al., 2009).

What about the naming? Using the term PCBRD does not seem like a very good option because it is quite pleonastic and no clinician or researcher has ever heard it before. The term Complicated Grief has the disadvantage that it may be confused with complicated bereavement, a term used to refer to depressive symptoms that "complicate" bereavement.

Retaining the term Prolonged Grief Disorder is, in our view, most appropriate because the persistence of intense and disabling acute grief is increasingly recognized as the central component of dysfunctional grief (cf. Wakefield, 2012).

In sum, including criteria for Prolonged Grief Disorder proposed by Prigerson, Horowitz and others (2009) to DSM-5 seems like a good alternative to the inclusion of PCBRD. However, a further alternative solution to the problems brought about by including PCBRD could be to expand the symptom-criteria listed under Criterion C with symptoms tapped by the Inventory of Complicated Grief (e.g., "preoccupation with thoughts/memories", "feeling drawn to places"). Although little time is left, in this last year before publication of DSM-5, clinicians and researchers could be consulted to finalize Criterion C, specifically with respect to the precise list of symptoms chosen from the Inventory of Complicated Grief and the optimal number of symptoms required for meeting this criterion.

Conclusion

The DSM-5 *Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group* has acknowledged that it is time to include dysfunctional grief in DSM-5 and proposed the inclusion of a bereavement subtype of Adjustment Disorder in the main body of the DSM-5, and the inclusion of PCBRD in Section III (APA, 2012a, 2012b). Although this could be considered a fortunate step, there are several arguments to oppose inclusion of PCBRD. First, there is no empirical evidence that criteria for PCBRD are reliable and valid. Second, PCBRD is a hastily conceived and extremely heterogeneous construct that endangers major advances in our understanding of what constitutes dysfunctional grief. It thereby sets the bereavement research and clinical clock backwards, and ignores major forward strides in current understanding, due to the availability of validated criteria that can be reliably assessed. Third, some of the proposed criteria overlap with uncomplicated, or "normal", grief. This is particularly disconcerting given the concerns about

medicalizing and stigmatizing normal responses to loss. Fourth, inclusion of PCBRD in DSM-5 will cause a discontinuity in clinical practice and research. Including these untested criteria would disrupt research efforts focused on the investigation of prevalence rates, risk factors, and treatments, which have all relied on descriptions of dysfunctional grief that differ significantly from the proposal for PCBRD and would complicate clinicians' efforts to integrate this research into their clinical work.

We feel that it is important that dysfunctional grief will become a formal condition in DSM-5 because that would facilitate research and would imply recognition of the suffering of a significant minority of bereaved individuals who experience difficulties in their process of recovery. However, it is important to consider whether the public health is served with the inclusion of PCBRD. We argued that including criteria for Prolonged Grief Disorder, possibly expanded with a few symptom-criteria that are tapped by the 19-item Inventory of Complicated Grief, seems like a good alternative to the inclusion of PCBRD. Why fix something that isn't broken? Keeping formal symptom-criteria limited to symptoms included in the Inventory of Complicated Grief would enable researchers to conduct reanalyses of previously collected datasets. Together with new field trials, such reanalyses could inform refinement of DSM-criteria for dysfunctional grief that are now likely to be put in the appendix, and support their possible movement to the main body of the DSM where they might well turn out to belong.

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Table 1
Criteria for Prolonged Grief Disorder, Complicated Grief, and Bereavement-Related Disorder

	Persistent Complex Bereavement-Related Disorder		**Complicated Grief**		**Prolonged Grief Disorder**
A	The person experienced the death of a close relative or friend at least 12 months earlier	A	The person has been bereaved, i.e. experienced the death of a loved one, for at least 6 months	A	Event: Bereavement (loss of a significant other)
B	Since the death at least 1 of the following symptoms is experienced on more days than not and to a clinically significant degree: 1. Persistent yearning/longing for the deceased 2. Intense sorrow and emotional pain because of the death 3. Preoccupation with the deceased person 4. Preoccupation with the circumstances of the death	B	At least one of the following symptoms of persistent intense acute grief has been present for a period longer than is expected by others in the person's social or cultural environment. 1. Persistent intense yearning or longing for the person who died 2. Frequent intense feelings of loneliness or like life is empty or meaningless without the person who died 3. Recurrent thoughts that it is unfair, meaningless, or unbearable to have to live when a loved one has died, or a recurrent urge to die in order to find or to join the deceased 4. Frequent preoccupying thoughts about the person who died, e.g. thoughts or images of the person intrude on usual activities or interfere with functioning	B	Separation distress: The bereaved person experiences yearning (e.g., craving, pining, or longing for the deceased; physical or emotional suffering as a result of the desired, but unfulfilled, reunion with the deceased) daily or to a disabling degree.
C	Since the death at least 6 of the following symptoms are experienced on more days than not and to a clinically significant degree: *Reactive Distress to the Death* 1. Marked difficulty accepting the death 2. Feeling shocked, stunned or emotionally numb over the loss 3. Difficulty in positive reminiscing about the deceased 4. Bitterness or anger related to the loss 5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame) 6. Excessive avoidance of reminders of the loss (e.g., avoiding places or people associated with the deceased) *Social/Identity Disruption*	C	At least two of the following symptoms are present for at least a month: 1. Frequent troubling rumination about circumstances or consequences of the death, e.g. concerns about how or why the person died, or about not being able to manage without their loved one, thoughts of having let the deceased person down, etc. 2. Recurrent feeling of disbelief or inability to accept the death, like the person cannot believe or accept that their loved one is really gone 3. Persistent feeling of being shocked, stunned, dazed or emotionally numb since the death 4. Recurrent feelings of anger or bitterness related to the death 5. Persistent difficulty trusting or caring about	C	Cognitive, emotional, and behavioral symptoms: The bereaved person must have five (or more) of the following symptoms experienced daily or to a disabling degree: 1. Confusion about one's role in life or diminished sense of self (i.e., feeling that a part of oneself has died) 2. Difficulty accepting the loss 3. Avoidance of reminders of the reality of the loss 4. Inability to trust others since the loss 5. Bitterness or anger related to the loss 6. Difficulty moving on with life (e.g., making new friends, pursuing interests) 7. Numbness (absence of emotion) since the loss

	7. A desire not to live in order to be with the deceased 8. Difficulty trusting other people since the death 9. Feeling alone or detached from other people since the death 10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased 11. Confusion about one's role in life or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased) 12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities)			other people or feeling intensely envious of others who have not experienced a similar loss 6. Frequently experiencing pain or other symptoms that the deceased person had, or hearing the voice or seeing the deceased 7. Experiencing intense emotional or physiological reactivity to memories of the person who died or to reminders of the loss 8. Change in behavior due to excessive avoidance or the opposite, excessive proximity seeking, e.g. refraining from going places, doing things, or having contact with things that are reminders of the loss, or feeling drawn to reminders of the person, such as wanting to see, touch, hear or smell things to feel close to the person who died. (Note: sometimes people experience both of these seemingly contradictory symptoms.)			8. Feeling that life is unfulfilling, empty, or meaningless since the loss 9. Feeling stunned, dazed or shocked by the loss
D	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.		D	The duration of symptoms and impairment is at least 1 month.		D	**Timing:** Diagnosis should not be made until at least six months have elapsed since the death.
E	Mourning shows substantial cultural variation; the bereavement reaction must be out of proportion or inconsistent with cultural or religious norms.		E	The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning, where impairment is not better explained as a culturally appropriate response.		E	**Impairment:** The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities).
	Specify if: *With Traumatic Bereavement:* Following a death that occurred under traumatic circumstances (e.g. homicide, suicide, disaster, or accident), there are persistent, frequent, and distressing thoughts, images, or feelings related to traumatic features of the death (e.g., the deceased's degree of suffering, gruesome injury, blame of self or others for the death), in response to reminders of the loss.					F	**Relation to other mental disorders:** The disturbance is not better accounted for by major depressive disorder, generalized anxiety disorder, or posttraumatic stress disorder.

Note. Criteria for Persistent Complex Bereavement-Related Disorder are from www.dsm5.org. Criteria for Complicated Grief are from Shear et al. (2011). Criteria for Prolonged Grief Disorder are from Prigerson et al. (2009).