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Prolonged grief disorder: clinical utility of ICD-11 diagnostic guidelines

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Abstract

Background. The World Health Organization (WHO) International Classification of Disease (ICD-11) is expected to include a new diagnosis for prolonged grief disorder (ICD-11_{PGD}). This study examines the validity and clinical utility of the ICD-11_{PGD} guideline by testing its performance in a well-characterized clinical sample and contrasting it with a very different criteria set with the same name (PGD_{PLOS}).

Methods. We examined data from 261 treatment-seeking participants in the National Institute of Mental Health (NIMH)-sponsored multicenter clinical trial to determine the rates of diagnosis using the ICD-11_{PGD} guideline and compared these with diagnosis using PGD_{PLOS} criteria.

Results. The ICD-11_{PGD} guideline identified 95.8% [95% confidence interval (CI) 93.3–98.2%] of a treatment-responsive cohort of patients with distressing and impairing grief. PGD_{PLOS} criteria identified only 59.0% (95% CI 53.0–65.0%) and were more likely to omit those who lost someone other than a spouse, were currently married, bereaved by violent means, or not diagnosed with co-occurring depression. Those not diagnosed by PGD_{PLOS} criteria showed the same rate of treatment response as those who were diagnosed.

Conclusions. The ICD-11_{PGD} diagnostic guideline showed good performance characteristics in this sample, while PGD_{PLOS} criteria did not. Limitations of the research sample used to derive PGD_{PLOS} criteria may partly explain their poor performance in a more diverse clinical sample. Clinicians and researchers need to be aware of the important difference between these two identically named diagnostic methods.

Introduction

The Trauma and Stress Disorder Workgroup of the World Health Organization (WHO) has proposed the inclusion of a new condition of prolonged grief disorder (ICD-11_{PGD}) in the International Classification of Disease (ICD-11). The guideline for ICD-11_{PGD} includes core features of yearning and/or preoccupation with the deceased accompanied by emotional pain. A list of examples of emotional pain is also provided and includes sadness, guilt, and difficulty accepting the death (World Health Organization). A recent case-controlled field study with more than 1700 international health workers demonstrated that this guideline was used correctly by 92% of clinicians (Keeley *et al.*, 2016).

There is a strong international agreement about the need for a diagnostic category for this condition, which is most commonly referred to in the literature as complicated grief. It has also been called unresolved (e.g. Lannen *et al.*, 2008) or traumatic grief (e.g. Prigerson *et al.*, 1999). Persistent impairing grief has been found in virtually every area of the globe, and the WHO workgroup recognized the public health burden of this condition. Moreover, violent loss or loss of a young person is associated with markedly increased risk for persistent impairing grief (Kaltman and Bonanno, 2003; Kristensen *et al.*, 2012) and these experiences are especially common in war-torn or low-income countries. Many countries that rely on the ICD are affected by disaster, war, conflict, widespread disease, and high rates of mortality. This means that recognition and effective intervention is of considerable importance to the WHO.

Diagnosis of persistent impairing grief is important because there is a strong evidence that this condition responds to targeted treatment (e.g. Wagner *et al.*, 2006; Boelen *et al.*, 2007; Rosner *et al.*, 2011; Kersting *et al.*, 2013; Bryant *et al.*, 2014); summarized in (Shear, 2015). Further, efficacy of targeted treatment is significantly better than for antidepressants (Shear *et al.*, 2016) or depression-focused psychotherapy (Shear *et al.*, 2005, 2014).

In the absence of a gold standard diagnosis, a new diagnostic criteria for a mental disorder should prioritize treatment need, clinical course, and response to treatment rather than be seen

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as a label for a disease process (Coggon *et al.*, 2005). Following this recommendation, we previously undertook a study of our treatment study participants to examine the performance of three major criteria sets for persistent impairing grief: persistent complex bereavement disorder (PCBD) (American Psychiatric Association, 2013), CG (Shear *et al.*, 2011), and PGD (PGD_{PLOS}) (Prigerson *et al.*, 2009). Results showed inadequate performance by PGD_{PLOS} as well as Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) provisional criteria for PCBD (Mauro *et al.*, 2017). These findings were later replicated in a community-based study (Cozza *et al.*, 2016).

The current study extends our previous findings by including an operationalized version of ICD-11_{PGD} guidelines. We compared the conditional probability of diagnosis by the ICD-11_{PGD} criteria for individuals with persistent impairing grief to the conditional probability of diagnosis by PGD_{PLOS} criteria. This comparison is important because of their shared name and different diagnostic approaches. The current study further examined whether there are clinical or demographic variables that affect diagnostic accuracy and how diagnosis relates to response to treatment.

Subjects and methods

Study participants with persistent impairing grief ($n = 261$) were enrolled at a university-based psychiatric research clinic at Columbia University ($n = 23$), Massachusetts General Hospital ($n = 82$), University of Pittsburgh Medical Center ($n = 72$), or University of California San Diego ($n = 84$) as part of the National Institute of Mental Health (NIMH)-funded collaborative treatment study (MH60783; MH85288; MH85308; MH85297). All participants were screened by telephone using the Brief Grief Questionnaire (Shear *et al.*, 2006) and in person using the Inventory of CG (ICG) (Prigerson *et al.*, 1995). Those who scored ⩾30 on the ICG and lost a loved one at least 6 months ago underwent an extensive baseline assessment. Those for whom eligibility was confirmed were then randomly assigned to receive study treatment. Participants were excluded if they presented with current substance use disorder (past 6 months), lifetime history of psychotic disorder, bipolar I disorder, cognitive impairment [Montreal Cognitive Assessment (Nasreddine *et al.*, 2005) score <21 or the Mini-Mental State (Folstein *et al.*, 1975) score <24], active suicidal ideation requiring hospitalization, concurrent psychotherapy, or pending lawsuit or disability claim related to the death. Assessments were completed between March 2010 and September 2014 (Shear *et al.*, 2016).

Bereaved participants without persistent impairing grief ($n = 86$) were enrolled in other ongoing research studies at the Latelife Depression Prevention and Treatment Center (P30 MH90333) at the University of Pittsburgh Medical Center ($n = 62$) or the Center for Anxiety and Traumatic Stress Disorders at the Massachusetts General Hospital ($n = 24$). Inclusion criteria for this bereaved sample without CG included an ICG score ⩽20 and a clinical interview in which a DSM-IV mood or anxiety diagnosis was considered to be the primary problem. Assessments were completed between April 2014 and August 2014.

Measures

At their baseline visit, study participants with persistent impairing grief provided demographic and loss-related information. A Structured Clinical Interview for DSM IV Disorders (SCID IV) (First *et al.*, 2002) with an additional module for CG [Structured Clinical Interview for CG (SCI-CG), see below] was completed by an experienced clinical rater trained to reliability and monitored throughout the study. Self-report measures of CG symptom severity and grief-related impairment were also obtained. At week 12 or 20, independent evaluators assessed treatment response, defined as a 1 ('very much improved') or 2 ('much improved') on the CG-anchored Clinical Global Impression – Improvement Scale (Guy, 1976; Shear *et al.*, 2005, 2016).

Bereaved participants without persistent impairing grief completed a grief symptom severity measure (ICG) and a self-report version of the structured interview (SCI-CG), as well as demographic information and more limited loss-related information.

Table 1. ICD-11_{PGD} guidelines and symptom matching with the SCI-CG

ICD-11_{PGD}	SCI-CG item
A persistent and pervasive grief response characterized by	
Longing for the deceased or	2. Yearning/longing
Persistent preoccupation with the deceased	4. Thoughts/images, 5. lost or absorbed in thoughts/daydreams
Accompanied by intense emotional pain. This may be manifested by experiences such as:	
Sadness	3. Intense feelings sorrow/pain
Guilt	12. Guilty/self-blaming thoughts about death
Anger	11. Bitter or angry about death
Denial	7. Trouble accepting
Blame	12. Guilty/self-blaming thoughts about death
Difficulty accepting the death	7. Trouble accepting
Feeling one has lost a part of one's self	30. Concerned/uncertain about role in the world/identity
An inability to experience positive mood	29. Very hard to experience joy or satisfaction without
Emotional numbness and	9. Emotionally numb
Difficulty in engaging w/social or other activities	25. Difficult to feel close to others

Participants who endorsed longing for the deceased or a preoccupation with the deceased and at least one symptom of intense emotional pain received an ICD-11_{PGD} diagnosis.

The Structured Clinical Interview for CG

SCI-CG is a 31-item semi-structured clinical interview that uses a SCID-like format and scoring (1 = 'absent', 2 = 'unsure or equivocal', 3 = 'present'). Ratings can be used to evaluate ICD-11_{PGD} guidelines as well as PGD_{PLOS}, PCBD, and CG criteria sets. The SCI-CG has good internal consistency (Cronbach's $\alpha = 0.76$) and test–retest reliability (ICC = 0.68) (Bui *et al.*, 2015). Copies of the instrument can be obtained at http://www.complicated-grief.columbia.edu.

The Inventory of CG

ICG is a 19-item self-report questionnaire. Each item is rated on a five-point scale, with responses ranging from 0 = 'never' to 5 = 'always'. The ICG is a well-validated measure of grief symptoms with prior evidence for good internal consistency (Cronbach's $\alpha = 0.94$) and test–retest reliability (0.80) (Prigerson *et al.*, 1995) that has been used in studies worldwide to identify the syndrome variously labeled CG or

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Table 2. PGD_{PLOS} criteria and symptom matching with the SCI-CG

PGD_{PLOS} criteria	SCI-CG item
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	2. Yearning/longing
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)	30. Concerned/uncertain about role in the world/identity
2. Difficulty accepting the loss	7. Trouble accepting
3. Avoidance of reminders of the reality of the loss	14. Avoid anything because it is a reminder
4. Inability to trust others since the loss	24. Difficulty trusting others without similar loss
5. Bitterness or anger related to the loss	11. Bitter or angry about death
6. Difficulty moving on with life (e.g. making new friends, pursuing new interests)	31. Difficult to pursue plans for future because cannot share anymore
7. Numbness (absence of emotion) since the loss	9. Emotionally numb
8. Feeling that life is unfulfilling, empty or meaningless since the loss	28. Life empty/no purpose
9. Feeling stunned, dazed, or shocked by the loss	8. Shocked/stunned

Participants who endorsed yearning for the deceased and at least five accompanying symptoms received a PGD_{PLOS} diagnosis.

PGD. According to the American Psychological Association website, 'this scale has a well-validated clinical cut point. Clients who score over 25 are considered at high risk for requiring clinical care' (American Psychological Association (n.d.); Prigerson *et al.*, 1995, 1996; Boelen *et al.*, 2003).

Operational definition of caseness

In order to evaluate the clinical utility of the diagnostic criteria sets, we first identified a valid and reliable measure of clinically significant distress and impairment. Based on the evidence that an ICG score of 25 or higher identifies clinically significant symptoms and to ensure that we were recruiting individuals clearly above the recommended ICG cut-score, study participants with persistent impairing grief were required to score 30 or higher on the ICG in order to be randomized in the parent study. In addition, they were judged by an experienced clinician to have CG as the condition most in need of treatment. All participants also responded affirmatively to the question: 'Overall, is grief interfering a lot with your ability to work or socialize or function in other ways?'. We also examined the rates of non-diagnosis among participants who had ICG scores below 20, which we consider a reliable indicator of the absence of persistent impairing grief.

Diagnostic algorithm

To operationalize the $ICD\text{-}11_{PGD}$ guideline and the PGD_{PLOS} criteria set, relevant symptoms were matched with individual items on the SCI-CG (see Tables 1 and 2). A symptom was considered present if the corresponding SCI-CG item was endorsed as 3 = 'present'. To be diagnosed using the $ICD\text{-}11_{PGD}$ guideline, participants needed to endorse longing for the deceased or preoccupation with the deceased, as well as at least one of the accompanying symptoms listed in Table 1. For exploratory purposes, we also examined varying the number of required accompanying symptoms for $ICD\text{-}11_{PGD}$. Participants met criteria for PGD_{PLOS} if they endorsed yearning and at least five of the nine accompanying symptoms listed in Table 2. Relative representation of SCI-CG items on the two criteria sets were similar; $ICD\text{-}11_{PGD}$ criteria were matched with 11 items from the SCI-CG, PGD_{PLOS} were matched with 10 items. Five symptoms were common to both.

Statistical methods

We examined clinical utility of the $ICD\text{-}11_{PGD}$ and PGD_{PLOS} criteria sets by determining the proportion of study participants diagnosed by each of the criteria sets in both the study sample with persistent impairing grief and the bereaved sample without persistent impairing grief. This was done by dividing the number of participants diagnosed by the total number of participants in the relevant study sample, to get the conditional probability of diagnosis. Ninety-five per cent confidence intervals (CIs) were computed using the standard formula for binomial proportions. Further analyses were only carried out among the study sample with persistent impairing grief. McNemar's test was used to test for differences in the rates of diagnosis by criteria set. To assess for differences between those diagnosed and not diagnosed on demographic, loss-related information, and treatment outcomes, two sample t tests (continuous measures such as age) and χ^2 tests (categorical variables such as loss type) were used. A two-sided p value of 0.05 or less was considered statistically significant. All analyses were carried out using SAS 9.4.

Results

Table 3 presents demographic, loss-related, and clinical characteristics of the two study samples. Study participants with persistent impairing grief were mostly female (79%), white (82%), non-Hispanic (87%), and well educated. There was a considerable variability in marital status, person who died, and type of death. Seventy-two per cent of participants had co-occurring current major depressive disorder (MDD) and 41% current post-traumatic stress disorder (PTSD). They were on average 52 years old and had

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Table 3. Demographic, loss-related, and clinical characteristics of the sample

	Treatment sample ($n = 261$)		Control sample ($n = 86$)	
	N or mean	% or s.d.	*N* or mean	% or s.d.
Gender (female)	205	78.5%	60	69.8%
Age, years	52.0	14.5	61.3	22.5
Race (white)	215	82.4%	69	80.2%
Ethnicity (Hispanic)	32	12.3%		
Education				
High school or less	28	10.7%		
Some college	81	34.9%		
Four-year degree or more	142	54.4%		
Marital status				
Never married	74	28.4%	22	25.6%
Married	55	21.1%	26	30.2%
Divorced/separated	44	16.9%	17	19.8%
Widowed	88	33.7%	21	24.4%
Time since loss, years, median (range)	2.1	0.5–42.0	12.9	1–69.3
Person who died				
Partner of the bereaved person	95	36.4%	15	17.4%
Parent of the bereaved person	76	29.1%	38	44.2%
Child of the bereaved person	50	19.2%	6	7.0%
Other relative or friend	40	15.3%	27	31.4%
Type of death				
Non-violent	174	66.7%	77	89.5%
Violent	87	33.3%	9	10.5%
Current MDD	190	72.8%		
Current PTSD	107	41.0%		

Table 4. ICD-11_{PGD} diagnosis rates when the number of required accompanying symptoms is varied

Required # of accompanying symptoms	Diagnosis rate (95% CI)
0	95.8 (93.3–98.2)
1	95.8 (93.3–98.2)
2	95.0 (92.4–97.7)
3	91.6 (88.2–94.9)
4	86.2 (82.0–90.4)
5	72.8 (67.4–78.2)
6	45.2 (39.2–51.3)

lost their loved ones around 2.1 years ago (range: 6 months to 42 years). The sample without persistent grief was also mostly female (70%) and white (80%), but were on average 9.3 years older and had longer time since loss (median = 12.9 years).

The ICD-11_{PGD} guideline correctly identified 250/261 (95.8%; 95% CI 93.3–98.2%) of the study participants with persistent impairing grief, while PGD_{PLOS} criteria diagnosed only 154/261 (59.0%; 95% CI 53.0–65.0%). These rates of diagnosis are significantly different from one another ($\chi^2 = 96.0$, df = 1, $p < 0.0001$). None of the bereaved sample without persistent grief was diagnosed by either the ICD-11_{PGD} or the PGD_{PLOS} criteria. Rates of ICD-11_{PGD} diagnosis were also examined when varying the number of required accompanying symptoms; results are presented in Table 4.

The outcome of our treatment study showed a robust response to CG therapy (CGT), which was clinically and statistically superior to placebo medication while we found no difference between antidepressant and pill placebo (Shear *et al.*, 2016). Given the variability in case identification by PGD_{PLOS} criteria, we wondered if these criteria might identify differences in treatment responsiveness. However, we found no indication for this. Among those who received CGT, there was no difference in treatment response among those who did or did not meet the PGD_{PLOS} criteria (85.2% *v.* 87.7%, $\chi^2 = 0.04$, df = 1, $p = 0.8345$). Adherence to therapy was also nearly identical between the two groups (70.6% *v.* 74.4%, $\chi^2 = 0.22$, df = 1, $p = 0.6377$). Participants who did not receive CGT were treated with medication and CGT-informed clinical management. Similar to those who received CGT, there was no difference in treatment response among those who did (57.5%) or did not (64.7%) meet PGD_{PLOS} criteria (57.5% *v.* 64.7%, $\chi^2 = 0.49$, df = 1, $p = 0.4831$). Given the high accuracy of ICD-11_{PGD} in this sample, we could not compare the rates of treatment response between those diagnosed and not diagnosed by ICD-11_{PGD}.

We next examined demographic or clinical variables that might affect diagnostic accuracy. Given that ICD-11_{PGD} identified 96% of the cases in this sample, we could not examine variables that might affect it. Comparisons of demographic, loss-related, and clinical characteristics of those diagnosed and not diagnosed by the PGD_{PLOS} criteria are given in Table 5. There were several variables that significantly affected whether PGD_{PLOS} criteria diagnosed these cases. Widows were more likely to receive a PGD_{PLOS} diagnosis (74%), than other participants, especially those who were married (38%) ($\chi^2 = 18.3$, df = 3, $p = 0.0004$, see Table 4). PGD_{PLOS} criteria were also more likely to identify those bereaved by loss of a partner (partner: 69%) compared with other losses (parent: 59%, child: 50%, other: 45%, $\chi^2 = 9.23$, df = 3, $p = 0.0264$), by a non-violent death [65% of non-violent *v.* 47% of violent deaths ($\chi^2 = 7.6$, df = 1, $p = 0.0058$)] and when there was a co-occurrence of MDD [64% of those with current MDD *v.* 45% of those without current MDD diagnosis ($\chi^2 = 7.8$, df = 1, $p = 0.0051$)].

Discussion

Persistent impairing grief, often known as CG, is a disabling condition that has been found throughout the world. Treatment studies conducted by our research group have established an efficacious short-term intervention for this disorder and documented low responsiveness to treatment for depression. Good clinical guidelines for assessment and treatment are essential for optimal public health initiatives, such as those envisioned by the WHO, in low-resource countries affected by high rates of natural and man-made disasters that are occasions for grief. The

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Table 5. Rates of PGD_{PLOS} diagnosis by demographic, loss-related, and clinical characteristics of the sample

	PGD_{PLOS} diagnosis			
	N	% Diagnosed	Test statistic (DF)	*p* value
Gender			0.09 (1)	0.7690
Female	120	58.5		
Male	34	60.7		
Age, years	–	–	−1.16 (259)	0.2466
Race			0.73 (2)	0.6937
White	129	60.0		
Black	16	57.1		
Other	9	50.0		
Ethnicity			0.11 (1)	0.7353
Hispanic	18	56.3		
Non-Hispanic	136	59.4		
Education			0.39 (2)	0.8233
High school or less	15	53.6		
Some college	54	59.3		
Four-year degree or more	85	59.9		
Marital status			18.3 (3)	0.0004[a]
Never married	44	59.5		
Married	21	38.2		
Divorced/separated	24	54.5		
Widowed	65	73.9		
Time since loss, years	–	–	1.28	0.1995
Person who died			9.23 (3)	0.0264[a]
Partner of the bereaved person	66	69.5		
Parent of the bereaved person	45	59.2		
Child of the bereaved person	25	50.0		
Other relative or friend	18	45.0		
Type of death			7.6 (1)	0.0058[a]
Non-violent	113	64.9		
Violent	41	47.1		
Current MDD			7.8 (1)	0.0051[a]
Yes	122	64.2		
No	32	45.1		
Current PTSD			1.0 (1)	0.3225
Yes	67	62.6		
No	87	56.5		

[a]Significant at $\alpha = 0.05$.

decision by the ICD-11 workgroup to include a diagnostic guideline for PGD is an important one. A recent field study also showed the ease of usability of the $ICD\text{-}11_{PGD}$ guideline (Keeley *et al.*, 2016). The current data provide preliminary evidence for endorsement of the ICD-11 guideline for PGD as a simple and effective approach that can be used to identify people likely to respond to a targeted treatment.

Clinicians and researchers need to be alert to two important issues related to the name given to this new ICD-11 diagnosis. First, this condition of PGD identified by ICD-11 is the same one that is often referred to in both the academic literature and public media as CG. Second, there are two criteria sets with the name PGD. Recent publications (Maciejewski *et al.*, 2016; Maciejewski and Prigerson, 2017) have obscured the difference between these two diagnostic approaches. Our results show that these two criteria sets actually have significantly different rates of diagnosis for individuals with clinically significant persistent impairing grief.

Maciejewski *et al.* (2016) attempted to develop an operationalized definition of $ICD\text{-}11_{PGD}$. To do so, the authors reanalyzed data from the Yale Bereavement Study (YBS), the same data that were also used to develop their criteria set for PGD_{PLOS} (Prigerson *et al.*, 2009). They utilized the same mathematically derived criterion standard that was used to develop PGD_{PLOS} criteria. In order to match $ICD\text{-}11_{PGD}$ to this criterion standard, the authors (Maciejewski *et al.*, 2016) found that multiple symptoms of persistent emotional pain were required for diagnosis. This is not consistent with the ICD-11 guideline instructions. Using an operationalization that matches the guideline, $ICD\text{-}11_{PGD}$ and PGD_{PLOS} criteria sets perform very differently. Performance of $ICD\text{-}11_{PGD}$ criteria only align with PGD_{PLOS} criteria in our sample when between five and six or more of the accompanying symptoms are required for diagnosis.

The findings reported here have been replicated in the Military Family Bereavement Study sample (Cozza *et al.*, n.d.) Additionally, these results resemble those reported by Forstmeier and Maercker (2007) in a population-based survey comparing Horowitz *et al.* (1997) criteria for CG to PGD_{PLOS} in older adults. Analyses in the latter paper showed that just one symptom in addition to yearning or preoccupation was adequate to diagnose CG.

As described previously (Reynolds *et al.*, 2017), the YBS was a limited sample and lacked sufficient clinical input into the definition of caseness. PGD_{PLOS} criteria were developed from the reports of widows who were bereaved for only 6–12 months. There is still uncertainty about the time period needed to diagnose this disorder, with little data to inform this decision. In DSM-5, a period of at least 12 months is required. Even if PGD can be diagnosed at 6 months, it is not clear that the criteria developed from data with such a limited time period will be adequate to diagnose the condition at later stages. In the current study, as well as most existing treatment studies (e.g. Shear *et al.*, 2005, 2016; Boelen *et al.*, 2007; Bryant *et al.*, 2014), the average time since the death is over 2 years. The YBS has no data pertaining to this period, which could partially explain the low diagnosis rate of PGD_{PLOS} in this study. We suggest that the users of ICD-11 be wary of overdiagnosis or misdiagnosis during the first year after a loss.

Our results may shed further light on the reasons for low rates of diagnosis by PGD_{PLOS} criteria. These criteria were less likely to diagnose those bereaved by violent causes, those who were currently married, or those not bereaved of a spouse. Prigerson *et al.* (2009) state that they consider widowhood following an older spouse's death from natural causes to be the prototype for bereavement. However, they acknowledge the need to confirm the findings in more diverse non-widowed samples and to

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examine longer term bereavement outcomes. Our data comprising a more diverse sample suggest that PGD_{PLOS} criteria perform differentially depending on comorbidities, relationship to the deceased, and circumstances of the death. Diagnostic criteria need to perform well in diverse clinical samples.

Our study has a number of limitations. First, our study lacked a gold standard for diagnosing the condition in question. However, this limitation is unavoidable when there are not yet validated or agreed-upon criteria. Instead, we used a rigorous reliable assessment procedure to determine clinical caseness. We required a score above the published and widely accepted cut-score on a well-validated symptom measure (ICG; Prigerson *et al.*, 1995), significant bereavement-related distress and impairment, and confirmation by a clinician that grief was the most important problem in need of treatment. In addition, our study sample was recruited from urban areas in a first world wealthy country and was primarily from the white middle class. This may limit the generalizability of this work. However, we found similar results in a larger more diverse community-based sample of bereaved military families (Cozza *et al.*, n.d.). Future studies need to include the full range of socio-economic levels, age, race, and ethnicity.

Lastly, we were only able to include individuals who we were confident were or were not experiencing the 'true' disorder. Therefore, we have no information about the middle group where the presence of the 'true' disorder is more ambiguous. Because of this, we are unable to determine sensitivity, specificity, or positive predictive power of these criteria. However, while such clinical samples are not representative of the general population, they are the most relevant group in need of diagnosis (Feighner *et al.*, 1972). In addition, the ability to accurately diagnose those who unambiguously have the disorder is a necessary, but not sufficient, condition for any criteria set to have good sensitivity. Our results show that $ICD\text{-}11_{PGD}$ meets this condition, but that PGD_{PLOS} do not. Similarly, the fact that none of the bereaved sample without persistent grief was diagnosed by the $ICD\text{-}11_{PGD}$ criteria is a necessary, but not a sufficient condition to ensure that these criteria are not overdiagnosing. One possible explanation for this finding is that those without persistent grief had been bereaved for a much longer period (median = 12.9 *v.* 2.1 years). Further research should continue to examine the performance characteristics of criteria sets in clinical and representative community-based samples that include people with and without prolonged, impairing grief who enter treatment, as well as those who do not enter treatment.

In conclusion, our data provide preliminary support for the validity and clinical utility of the proposed $ICD\text{-}11_{PGD}$ guideline for diagnosing people currently considered to have complicated, prolonged, unresolved, or traumatic grief. Given the estimated prevalence and the availability of efficacious treatment, there is a pressing need to establish and disseminate clinically useful diagnostic guidance for clinicians working with grieving patients. The brief and parsimonious approach used for the $ICD\text{-}11_{PGD}$ guideline optimizes its usefulness for busy clinicians. Our data provide incremental support for the adoption of $ICD\text{-}11_{PGD}$. It also demonstrates that $ICD\text{-}11_{PGD}$ and PGD_{PLOS} are not diagnosing the same people. It is important for clinicians, researchers, and the general public to be aware of this distinction.

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Conflict of interest. Dr Mauro reports no competing interests. Dr Reynolds reports no competing interests. Dr Maercker is a member of the WHO ICD-11 Working Group on the Classification of Disorders Specifically Associated with Stress, reporting to the WHO International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. The views expressed in this article are those of the author and do not represent the official policies or positions of the WHO. Dr Skritskaya reports no competing interests. Dr Simon reports no competing interests. Dr Zisook reports no competing interests. Dr Lebowitz reports no competing interests. Dr Shear reports a contract with Guilford Press to write a book on grief.

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