VIEWPOINT

Rebuilding Consensus on Valid Criteria for Disordered Grief

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Viewpoint

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Are complicated grief criteria better for diagnosing grief disorder than prolonged grief disorder criteria?—No.

Overview

In 2009, following the completion of a National Institutes of Health/National Institute of Mental Health–funded investigation of consensus criteria for disordered grief, we published validated criteria for a new diagnostic entity, prolonged grief disorder (PGD).[1] Based on the results of this field trial, the Yale Bereavement Study (YBS), we proposed PGD's inclusion in the *DSM 5* and the *International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (ICD-11)*. The strength of the evidence in support of PGD from the YBS, supplemented by confirmatory findings from multiple international studies, compelled both the *DSM* and *ICD* to include a new grief disorder.

The formulations of the *DSM* and the *ICD* of diagnostic criteria for a grief disorder agree with PGD criteria.[2] They also share the psychometric properties of PGD. By contrast, complicated grief (CG) criteria[3] do not agree with *DSM* and *ICD* criteria, use abstruse syntax, produce more false-positive than true-positive diagnoses, and lack predictive validity.[2] Evidence supports the validity of PGD[1] and its *DSM* and *ICD* derivatives[2] but weighs against the validity of CG.[2] Prolonged grief disorder meets established criteria for a mental disorder,[4] but CG does not. Based on existing evidence, PGD criteria should be the standard for diagnosing disordered grief.

Methodological Misgivings

Presumably, medical journals only publish studies that use standard, scientifically sound methods. Standard information for evaluating diagnostic criteria includes estimates of diagnostic accuracy (eg, sensitivity and specificity) and the prevalence of a disorder. Curiously, this information is absent from the study from Cozza et al,[5] which concludes that CG criteria are superior to PGD and persistent complex bereavement disorder criteria. In the YBS data,[2] CG criteria produce more false-positive cases (63%) than true-positive cases (37%) of disorder and have an unacceptably high (30%) overall rate of diagnosis. Based on the YBS results, we expect that the unreported overall rate of diagnosis of CG and the false-positive CG test result rate in the entire Cozza et al[5] sample are unacceptably high.

The results of Cozza et al[5] are "spectrum-biased." They discard nearly half (n = 797, 46%) of their total sample to focus on the most obvious "cases" (n = 260, 15%) and "controls" (n = 675, 39%). Spectrum bias[6] in estimates of diagnostic accuracy results from excluding less obvious, borderline cases in favor of extreme, easier to evaluate cases and controls. Spectrum-biased designs overestimate sensitivity and specificity by omitting diagnostic errors from near-threshold cases. The real test of diagnostic performance is not identifying extremes, but rather discerning in-between, more difficult to evaluate cases. The spectrum-biased design of Cozza et al[5] does not account for the many false-positive test results for CG that would have appeared in the large excluded segment (46%) of their analytic sample. Most likely (and, if so, consistent with findings from the YBS),[2] there are more false- than true-positive test results for CG in their full sample.

Prevalence rates and rates of false-positive and negative results obtained for the full sample (not a spectrum-biased group of cases and controls) are needed to determine which criteria sets have superior performance. Essential missing information and using a spectrum-biased design raise questions concerning the scientific soundness of the CG proposal.

CG Criteria Pathologize Normal Grief

Bereavement is a common, natural life event. It is normal to be upset following the loss of someone loved, and heightened vigilance is needed to avoid pathologizing normal reactions. For this reason, diagnostic criteria for grief disorder should prioritize diagnostic specificity (minimizing false-positive results) over sensitivity (minimizing false-negative results). Complicated grief criteria, lax in number and the severity of symptoms required for a diagnosis, produce many false-positive results, overdiagnose grief disorder, and pathologize normal grief. Applying the "moderate" symptom severity threshold used by Cozza et al[5] to CG criteria[3] that require only 3 symptoms for a diagnosis, the positive result test rate for CG in the YBS sample is 62%. Thus, CG criteria diagnose most bereaved individuals in a community sample as mentally ill—a result that undermines their face validity (eg, laypersons are likely to consider such criteria suspect).

Straw Men Arguments

Suggestions that CG criteria are superior to PGD criteria by embodying clinical wisdom or applicability are straw men arguments. These claims strive to shift attention away from important issues of diagnostic assessment such as diagnostic validity and accuracy. Diagnostic validity must be established before proceeding to clinical applications; it does not make sense to discuss the clinical applications of invalid diagnoses.

We recognize that clinical insight is essential to forming psychiatric diagnoses. Prolonged grief disorder, like CG, was informed by the clinical insight of prominent psychiatrists (eg, Drs Parkes, Horowitz, Jacobs, Shear, and

Reynolds). However, clinical opinion alone is insufficient for the validation of diagnostic criteria. Clinical insight was translated into a National Institutes of Health/National Institute of Mental Health–funded investigation of consensus criteria for PGD that produced compelling evidence of a new diagnostic entity.[1] By contrast, CG criteria were introduced in a review article[3] without any empirical support or evidence of predictive validity.[2] Given how easily CG criteria can be satisfied, they also lack face validity.

The claim that CG criteria, compared with PGD criteria, identify a greater number of individuals who will benefit from treatment is another straw man argument. The main purpose of diagnostic assessment is to determine whether an individual has a disorder. To paraphrase *DSM-5*, an accurate diagnosis is a prerequisite for appropriate treatment. Any argument about the superior clinical applicability of CG criteria diverts attention away from diagnostic accuracy to the presumed need of bereaved individuals for clinical care. As Spitzer wrote, "To confuse making a mental disorder diagnosis with demonstrating treatment need [is]… a serious mistake."[7]

Moreover, there is no evidence to our knowledge that CG criteria accurately identify bereaved individuals in need of, or likely to benefit from, treatment. We found that CG criteria, unlike PGD criteria, were unrelated to the risk of a future mental disorder, functional impairment, or diminished quality of life.[2] Thus, CG criteria do not identify bereaved individuals at risk of enduring dysfunction who might be helped by an intervention. There is no evidence to our knowledge that CG criteria are better than PGD criteria regarding any clinical process or outcome. These lines of argument aim to draw attention away from fundamental issues of diagnostic performance (eg, prevalence, false-positive result rates, and predictive validity) to prematurely focus on issues of clinical application.

Conclusions

Data from multiple independent community-based data sets tell a consistent, compelling story that supports the diagnostic validity and accuracy of PGD criteria. This is not true for CG criteria. Complicated grief criteria lack validity,[2] produce more false- than true-positive test results for disorders,[2] and, because they are too easily satisfied, pathologize normal grief. Prolonged grief disorder criteria reliably and validly identify bereaved individuals genuinely in need of and likely to benefit from seeing a mental health professional. Complicated grief criteria are inadequate and counterproductive and should be withdrawn from serious consideration. It is time for scientists and clinicians to agree that PGD should be adopted as the standard for diagnosing disordered grief.

ARTICLE INFORMATION

Published Online: March 29, 2017. doi:10.1001/jamapsychiatry.2017.0293

Conflict of Interest Disclosures: Dr Prigerson received support from grant MH56529 from the National Institute of Mental Health for the collection of data for testing consensus criteria for disordered grief. Dr. Prigerson's Outstanding Investigator Award (NCI R35: CA197730) from the National Cancer Institute also supported the preparation of this article.

REFERENCES

1. Prigerson HG, Horowitz MJ, Jacobs SC, et al. Prolonged grief disorder: psychometric validation of criteria proposed for *DSM-V* and *ICD-11*. *PLoS Med*. 2009;6(8):e1000121.

2. Maciejewski PK, Maercker A, Boelen PA, Prigerson HG. "Prolonged grief disorder" and "persistent complex bereavement disorder," but not "complicated grief," are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. *World Psychiatry*. 2016;15(3):266-275.

3. Shear MK, Simon N, Wall M, et al. Complicated grief and related bereavement issues for *DSM-5*. *Depress Anxiety*. 2011;28(2):103-117.

4. Feighner JP, Robins E, Guze SB, Woodruff RA Jr, Winokur G, Munoz R. Diagnostic criteria for use in psychiatric research. *Arch Gen Psychiatry*. 1972;26(1):57-63.

5. Cozza SJ, Fisher JE, Mauro C, et al. Performance of DSM-5 persistent complex bereavement disorder criteria in a community sample of bereaved military family members. *Am J Psychiatry*. 2016;173(9):919-929.

6. Ransohoff DF, Feinstein AR. Problems of spectrum and bias in evaluating the efficacy of diagnostic tests. *N Engl J Med*. 1978;299(17):926-930.

7. Spitzer RL. Diagnosis and need for treatment are not the same. *Arch Gen Psychiatry*. 1998;55(2):120.