Proposed Developmental Modifications to the Panel Draft Criteria for Prolonged Grief Disorder in DSM-5-TR

Note: These developmental recommendations are extracted from our Developmental Modifications Final Report, available at this website and from the first author:

> Layne, C. M., Oosterhoff, B., Pynoos, R. S., & Kaplow, J. B. (4 February 2020). *Developmental Analysis of Draft DSM 5-TR Criteria for Prolonged Grief Disorder: Report from the Child and Adolescent Bereavement Subgroup*. Report submitted to the Panel on Developing Criteria for a Disorder of Pathological Grieving for DSM 5-TR (P. Applebaum, Chair). American Psychiatric Association.

What Can I Say in the Public Commentary?
A Quick Summary of Our Developmental Recommendations

We recommend that the following developmental modifications be made to Prolonged Grief Disorder (PGD) in DSM-5-TR:

1. *Criterion A should be shortened to 6 months for bereaved children and adolescents. This is not only because 12 months is an extremely long time to wait for services if a child is suffering from clinically severe grief reactions, but also due to the risk for serious disruptions in key developmental tasks if no grief diagnosis can be made before 12 months have passed since the death.*

2. *Criterion B should be split into two symptoms with a developmental modification for B2. We have observed that bereaved children may experience these distressing preoccupations over the manner of death even if they have not been exposed to "traumatic death" as defined by PTSD Criterion A, or do not manifest other significant PTSD symptoms.*
    - (B1) Intense yearning/longing for the deceased person.
    - (B2) Preoccupation with thoughts or memories of the deceased person. (Children and adolescents may also present with distressing preoccupation with the circumstances of the death.)

3. A Text Note should be added to the Development and Course Section of DSM-5-TR regarding Symptom B1(intense yearning/longing for the deceased person) as it may manifest in bereaved children:

    Young children may express yearning in thought or play as a wish to literally physically reunite with the deceased (e.g., to climb a ladder to heaven, or lie in the ground next to them). This reunion fantasy may sometimes take the form of a wish to die or fantasies of dying. However, it is not suicidal ideation stemming from feeling that one cannot go on without the person. Rather, young children's wishes or fantasies express, in concrete thinking, a way to overcome the painful physical separation (Kaplow, Layne, Pynoos, Cohen & Lieberman, 2012). Adolescents can express suicidal thinking similar to reports in adults.
4. I have also reviewed and endorse the developmental notes as listed in the Child & Adolescent Development Team's Developmental Recommendations Final Report (Layne, Oosterhoff, Pynoos, & Kaplow, 2020).

Overview to the Detailed Discussion of Our Developmental Recommendations

Our team (Layne, Oosterhoff, Pynoos, & Kaplow, 2020) has carefully considered the proposed PGD criteria and discussed them at length. In this process we have drawn on our published papers and research experience, other published papers, clinical experience, and new analyses conducted with our data sets to address the Panel's questions. Our proposed additions to the symptom and accompanying text are highlighted in yellow.

Part 1: Proposed Developmental Modifications to Prolonged Grief Disorder Draft Criteria

In this section, we insert our recommended modifications to the draft criteria highlighted in yellow. Please note that we have broken Criterion B, which we consider double-barreled, into two separate items. We did this to make it more comprehensible and straightforward for assessing bereaved children and adolescents, who are easily confused by complex wording. We use this breakdown in our subsequent analyses, presented below, and find that the two B items perform well psychometrically.

A. The death of a person close to the bereaved at least 12 months previously (for children and adolescents, at least 6 months previously).

Comment: We recommend that Criterion A be shorted to 6 months for bereaved children and adolescents.

B. Since the death, there has been a grief response characterized by one or both of the following two symptoms:
   1. Intense yearning/longing for the deceased person.
   2. Preoccupation with thoughts or memories of the deceased person. (Note: In children and adolescents, preoccupation may focus on the circumstances of the death.)

   This response has been present to a clinically significant degree nearly every day for at least the last month.

One Proposed Text Note for the Development and Course Section of DSM-5-TR:

The following proposed text note specifically refers to proposed PGD symptom B1 (intense yearning/longing for the deceased person) as it may manifest in bereaved children:

Young children may express yearning in thought or play as a wish to literally physically reunite with the deceased (e.g., to climb a ladder to heaven, or lie in the ground next to them). This reunion fantasy may sometimes take the form of a wish to die or fantasies of dying. However, it is not suicidal ideation stemming from feeling that one cannot go on without the person. Rather, young children's wishes or fantasies express, in concrete thinking, a way to overcome the painful physical separation (Kaplow, Layne, Pynoos, Cohen & Lieberman, 2012). Adolescents can express suicidal thinking similar to reports in adults.

Comment: We recommend that:

- ***Criterion B be divided into two symptoms instead of conflating them into a single***

compound symptom.

- ***Criterion B include preoccupation with the circumstances of the death as a clinical manifestation observed in bereaved children and adolescents, in that we have observed such distressing preoccupations in many youth who have been exposed to deaths that do not meet PTSD Criterion A (exposure to a traumatic life experience).***
- ***Criterion B include a note in the supporting text that young children may fantasize about physically reuniting with the deceased that may take the form of a wish to die or fantasies of dying. However, rather than reflecting suicidal ideation, these wishes and/or fantasies reflect concrete ideation about how to physically reunite with their loved one. That is, instead of reflecting despair, it represents a young child's solution to the problem of how to physically reunite with the deceased.***

C. As a result of the death, at least x of the following symptoms have been experienced to a clinically significant degree, nearly every day, for at least the last month:

1. Identity disruption (e.g., feeling as though part of oneself has died). (Note: Children and adolescents may express this discontinuity as now feeling different from others and often self-conscious as a result, e.g., weird or different as a result of being motherless.)

   Comment: We recommend that C1 include support text describing different ways in which identity disruption may be phenomenologically experienced by bereaved children and adolescents.

2. Marked sense of disbelief about the death. (Note: Young children may not understand the permanence of death.)

   Comment: We recommend that C2 include supporting text clarifying that younger children may not understand the permanence of death, and that belief that the parent may return may not necessarily reflect pathological disbelief.

3. Avoidance of, or efforts to avoid, reminders that the person is dead.

   Comment: We recommend that C3 include text clarifying that children may not have sufficient control over their daily activities to successfully avoid reminders of the death (e.g., a parent may decide to take them to the loved one's grave). Rather, this may be manifest in efforts to avoid the reminder, even if not successful.

4. Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death. (Note: This may be motivated in children and adolescents by feeling deprived of the person's help in responding to developmental needs.)

   Comment: We recommend that C4 include supporting text clarifying that intense emotional pain may reflect feelings of deprivation over not having the person available to help them cope with developmental needs (e.g., homework, attending

school activities and rites of passage, menses, providing advice about dating or future life choices).

5. Difficulty moving on with life (e.g., problems engaging with friends, pursuing interests, planning for the future). (Note: In children, this may take the form of inability to achieve developmental milestones).

   Comment: We recommend that C5 include supporting text clarifying that children may manifest difficulty with moving on as experiencing difficulties in achieving key developmental tasks and passing age- and culturally-appropriate developmental milestones (e.g., passing grades at school, forming future aspirations, reluctance to form romantic relationships or to marry/establish stable families).

6. Emotional numbness. (Note: Young and school-age children may not understand or describe numbing. Adolescents may describe "not feeling anything.")

   Comment: We recommend that C6 include supporting text clarifying that children may lack the psychological insight needed to describe emotional numbing, and that adolescents may use different terminology to describe the experience of numbing.

7. Feeling that life is meaningless. (Note: Older children and adolescents may express this as "it's not worth trying," "nothing really matters anymore" or "my life is ruined.")

   Comment: We recommend that C7 include supporting text clarifying that children and adolescents may manifest this symptom as nihilism, resignation, or perceiving that their life is ruined and their future blighted as a consequence of the loss.

8. Intense loneliness (i.e., feeling alone or detached from others).

   Comment: We do not recommend any developmentally-based modifications to C8.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The duration of the bereavement reaction clearly exceeds expected social, cultural or religious norms for the individual's culture and context.

F. The symptoms are not better explained by another mental disorder.

Comment: We made no formal recommendations for making developmentally-based modifications to PGD Criteria D, E, and F.