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Are ‘time’ and ‘culture’ useful and necessary diagnostic requirements for ICD-11 Prolonged Grief Disorder? A Cross-national study

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ABSTRACT

ICD-11 PGD can only be diagnosed if symptoms persist beyond 6 months after bereavement and for longer than would be expected from societal, cultural, or religious norms. This study examined the validity and utility of these diagnostic requirements using self-report cross-sectional data from samples of bereaved adults from the United Kingdom (UK; $n = 1,012$), Ireland (Ireland; $n = 1,011$), and Ontario ($n = 1,167$). PGD symptoms and rates of probable PGD were not markedly higher in those bereaved within the last 6 months, and participants didn't view 6 months as the normative timeframe to come to terms with a bereavement. Approximately a quarter of those meeting symptom and impairment requirements couldn't determine if their grief exceeded cultural norms. Applying time and cultural requirements significantly reduced diagnosis rates. We argue that these findings may undermine the validity and clinical utility of these diagnostic requirements.

Introduction

Following decades of research detailing the negative psychological effects of bereavement and calls for a formal psychiatric diagnosis related to pathological grief (Prigerson et al., 2021; Shear & Shair, 2005; Simon et al., 2020), “Prolonged Grief Disorder” (PGD) was added to the 11th version of the *International Classification of Diseases (ICD-11)* (World Health Organization [WHO], 2019). *ICD-11* PGD is defined by “core” symptoms of persistent longing for the deceased and preoccupation with the deceased, accompanied by “associated” symptoms such as difficulty accepting the death, low mood, and emotional numbness that collectively disrupt daily functioning. *ICD-11* specifies that the grief response must have persisted for more than six months at a minimum and that symptoms must clearly exceed what would be expected based on social, cultural, or religious norms. Including the time and culture requirements was an attempt to placate concerns that a grief disorder would pathologize normal reactions to bereavement [WHO, 2019; Cacciatore & Francis, 2022; Eisma, 2023; Reed et al.,

2022), and would be difficult to implement internationally given the various social, cultural, and religious norms that exist relating to bereavement (Hilberdink et al., 2023; Stelzer et al., 2019). While the reasons for including these requirements are understandable, they imply several things that may not withstand empirical scrutiny and may be difficult to implement in clinical practice, which could undermine the validity and utility of the diagnosis.

The requirement that symptoms persist for longer than six months at a minimum implies that there may be a “normal” or “expected” timeframe within which most people come to terms with their loss. The *ICD-11* specifically states that “*The grief response has persisted for an atypically long period of time following the loss (more than 6 months at a minimum) ...*” (underline added for emphasis), and it has been noted that the purpose of the 6-month criterion was to “... achieve a balance between capturing a pathological grief reaction and not misdiagnosing normative grief” (Reed et al., 2022). This suggests that PGD symptoms are more common in the immediate aftermath of a loss but become less typical when they persist beyond

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six months. If this interpretation holds true, one would expect to observe high levels of PGD symptoms, and many people meeting diagnostic requirements, in the initial weeks and months after bereavement, followed by a sharp decline in both symptoms and diagnoses after six months.

Several studies have modeled trajectories of grief symptoms (i.e., different patterns of symptom expression over time) following bereavement. Many of these studies tracked changes in grief beginning about one year or more after bereavement and are therefore not relevant in determining if most people report symptoms of grief in the immediate aftermath of bereavement, and if there is a natural recovery point around 6 months post-bereavement (Kristensen et al., 2020; Lenferink et al., 2020; Sveen et al., 2018). Focusing on those studies that tracked grief symptoms from either shortly before (Nielsen et al., 2019) or immediately after bereavement (Bonanno & Malgaroli, 2020; Djelantik et al., 2022; Lundorff et al., 2020; Nam, 2015), there is consistent evidence that (1) most people (upwards of 70%) report continually low levels of grief after bereavement, (2) a small proportion of people (5–25%) report high levels of grief that do not decline over time, and (3) a small proportion of people (5–25%) report high levels of grief that do decline over time, however – and importantly – the decline is gradual in nature and is not characterized by a marked decline around six months post-bereavement which would be expected if six months or longer is considered an “*atypically long period of time*” to grieve. Similar effects are seen at the diagnostic level. In a longitudinal study of older adults who lost their spouse, 20.9% screened positive for PGD two months post-bereavement, 18.9% screened positive at six months post-bereavement, and 13.4% screened positive at eleven months post-bereavement (Lundorff et al., 2021). Thus, the empirical evidence indicates that in the initial weeks and months after bereavement, most people do not report high levels of grief or meet diagnostic requirements for PGD, nor does grief resolve for most people who experience these problems within six months.

The *ICD-11* description of PGD attaches no additional conditions to the time criterion, thereby implying that six months is the typical grieving period irrespective of factors such as one’s relationship to the deceased. However, there is considerable evidence that an individual’s relationship to the deceased is a potent risk factor for more intense and persistent grief reactions, with the loss of a child and a spouse being especially pernicious (Doering et al., 2022; Lobb et al., 2010; Shevlin et al., 2023). Thus, the six month

criterion in *ICD-11* makes the improbable, and so far unsupported assumption that a person’s relationship to the deceased has no effect on how long it takes for grief to resolve.

A recent study highlighted concerns about the related criterion that symptoms must persist for longer than expected in one’s social, religious, or cultural context (Redican et al., 2024). In their study of bereaved spouses and their adult children in Denmark, the authors noted that many people were unable to say definitively if their grief reactions exceeded cultural expectation, raising concerns about the potential for false-negative diagnoses. This criterion assumes that there are culturally accepted and agreed upon normative periods of time to come to terms with bereavement, and that clinicians or people themselves know what these periods are. We are not aware of any studies that have assessed people’s understandings of typical grieving periods in their own cultures, nor of clinicians’ knowledge of normative grieving periods in different cultures, religions, and societies (assuming there are normative periods of grieving within and across such contexts). This is important because diagnoses in *ICD-11* were developed to maximize clinical utility (Eisma, 2023), but this criterion places clinicians in the potentially difficult position of having to know the normative grieving periods for every conceivable culture, religion, and/or social group that their patients might live within to make a diagnosis. This does not seem to be an optimal way to maximize clinical utility.

In this study, we explored the validity and utility of the “time” and “culture” requirements in *ICD-11* PGD. We analyzed data from three large, culturally distinct samples of bereaved adults from the United Kingdom of Great Britain and Northern Ireland (UK), Ireland, and Ontario, Canada to test four research objectives. The first objective was to compare *ICD-11* PGD symptom scores and probable PGD rates in people bereaved within the last six months to those bereaved longer ago. If the *ICD-11* assumption is correct, PGD symptoms and probable PGD rates should be significantly and substantially higher in those bereaved within the last six months compared to those bereaved for longer. The second objective was to determine people’s beliefs about what constitutes a normal period of time required to come to terms with the loss of different loved ones (i.e., a parent, a child, a friend etc.). The *ICD-11* considers a grief response lasting over six months as “atypical” and assumes a typical grieving period of six months irrespective of one’s relationship to the deceased. Therefore, this objective will test if the general public

believes this to be the case. The third objective was to ascertain what proportion of bereaved people in each sample could unequivocally say that their grief reaction has, or has not, persisted for longer than would be expected in their cultural or community context. The *ICD-11* assumes that there is a normal grieving period within cultures, and this tests if people can provide a clear response when asked about this issue. The final objective was to determine if probable PGD rates significantly differed when the time and culture requirements were and were not applied. This tests the effect these requirements have on probable PGD rates and given that their inclusion was intended to reduce false-positive diagnoses (Eisma, 2023) it can be hypothesized that rates will be significantly lower when they are used to when they are not.

Method

Participants and procedures

Data were collected from three samples of bereaved adults from the UK ($N=1,012$), Ireland ($N=1,011$), and Ontario ($N=1,170$). All participants were recruited by the survey company Qualtrics and were drawn from existing national research panels. Qualtrics collaborates with numerous country-specific research panel providers to recruit participants from a vast pool of potential candidates via email, SMS, or in-app notifications. Previous research indicates that these samples are highly representative of the target populations (e.g., Boas et al., 2020). Quota sampling was employed by Qualtrics who recruited participants in each nation/region based on the sex, age, and geographic distributions of the population. Inclusion requirements were the same in each case and required participants to be aged 18 years or older and have experienced a lifetime bereavement. Data collection took place online with the UK data being collected from 19 April to 13 August 2022, the Irish data being collected from 21 April to 12 September 2022, and the Ontario data being collected from 3 August 2023 to 23 October 2023.

To determine the minimum required sample sizes, an a priori power analysis was conducted to detect a disorder with an assumed prevalence rate of 2.4% among bereaved adults (see Shevlin et al., 2023, for justification), with a precision of 1%, and a confidence level of 95%. This resulted in a required sample size of $N=900$. Ethical approval was provided by the research ethics committee at Ulster University for the UK and Irish studies and by the research ethics committee at Maynooth University Ireland for the Ontario

study. Demographic details for each sample are presented in Table 1.

Measures

Bereavement

Participants were asked to identify their relationship to the deceased, and if reporting multiple bereavements to select the most distressing bereavement. They were then asked how long ago this person died and were provided with seven options: (1) within the last 6 months, (2) 6–12 months ago, (3) 1–2 years ago, (4) 2–3 years ago, (5) 3–5 years ago, (6) 6–10 years ago, and (7) more than 10 years ago.

ICD-11 PGD

PGD symptoms were assessed using the International Grief Questionnaire (IGQ; Hyland et al., 2024) which captures all diagnostic requirements for *ICD-11* PGD. Participants were instructed to answer all questions thinking about their most distressing bereavement. The IGQ includes five items, two measuring the “core” symptoms of longing for the deceased and preoccupation with the deceased, and three measuring the “associated” symptoms of guilt and anger, difficulty accepting the death, and sadness and emotional numbness. Participants indicate how bothered they have been by each symptom in the last week on a five-point Likert scale with response options of “Not at all” (0), “A little bit” (1), “Moderately” (2), “Quite a bit” (3), and “Extremely” (4). Symptom scores can range from 0 to 20 with higher scores indicating greater symptom severity. Symptom presence is indicated by scores ≥ 2 (“Moderately”) on the Likert scale. Internal reliability of the scale scores in the UK ($\alpha = .94$), Irish ($\alpha = .92$), and Ontario ($\alpha = .93$) samples was excellent.

The criterion related to symptoms exceeding social, cultural, or religious norms was assessed by a single question: “Do you consider your grief to be worse (more intense and/or of longer duration) than what would be normally expected in your community or culture?” Three response options were provided including “No,” “Yes,” and “I don’t know.” Functional impairment was assessed by a single question with a “Yes” or “No” response format: “Have these experiences caused problems in personal, family, social, educational, occupational, or other important areas of your life?” Probable *ICD-11* PGD requires (1) bereavement, (2) bereavement occurring more than six months ago, (3) presence of at least one “core” symptom, (4) presence of at least one “associated” symptom, (5) answering “Yes” or “I don’t know” to the question that responses

Table 1. Sociodemographic details of the sample participants.

UK (N=1012)		Ireland (N=1011)		Ontario (N=1,170)	
<i>Sex</i>		<i>Sex</i>		<i>Sex</i>	
Female	51.3	Female	52.5	Female	54.6
Male	47.9	Male	47.3	Male	44.3
<i>Age</i>		<i>Age</i>		<i>Age</i>	
1–24	9.5	18–24	9.2	18–24	8.8
25–34	20.2	25–34	20.3	25–34	17.1
35–44	19.9	35–44	20.1	35–44	16.5
45–54	18.8	45–54	18.8	45–54	17.7
55+	31.7	55+	31.7	55+	39.8
<i>Place of birth</i>		<i>Place of birth</i>		<i>Place of birth</i>	
UK	94.6	Ireland	76.9	Canada	76.2
<i>Living location</i>		<i>Living location</i>		<i>Living location</i>	
City	23.6	City	20.5	City	68.5
Suburb	25.6	Suburb	22.8	Small village	2.2
Town	32.4	Town	25.5	Town	18.0
Rural area	18.4	Rural area	31.2	Rural area	11.3
<i>Income</i>		<i>Income</i>		<i>Income</i>	
0–£19,999	36.5	0–€19,999	24.9	0–\$30,000	36.3
£20,000–£39,999	44.0	€20,000–€39,999	38.9	\$30,000–\$49,999	20.5
£40,000–£59,999	13.7	€40,000–€59,999	21.3	\$50,000–\$69,999	16.7
£60,000–£79,000	4.2	€60,000–€79,000	9.6	\$70,000–\$89,000	10.2
£80,000 or more	1.7	€80,000 or more	5.3	\$90,000 or more	16.2
<i>Ethnicity</i>		<i>Ethnicity</i>			
British	79.8	Irish	76.5	–	–
British/Irish	12.0	British/Irish	11.5	–	–
Indian	1.1	Indian	0.8	–	–
Pakistani	1.7	Pakistani	1.7	–	–
Chinese	0.8	Chinese	2.0	–	–
Other Asian	0.3	Other Asian	0.4	–	–
African	0.7	African	1.6	–	–
Afro-Caribbean	0.1	Other ethnic group	8.4	–	–
Other ethnic group	3.4	Arab	0.2	–	–
Arab	0.2	Bangladeshi	0.1	–	–
<i>Education</i>		<i>Education</i>		<i>Education</i>	
No Qualifications	3.7	No Qualifications	0.7	No college degree	37.0
GCSE or similar	23.0	Mandatory school	6.3	College degree or higher	62.6
A-level or similar	20.3	Secondary school	22.2	–	–
Technical qualification	22.8	Technical qualification	15.2	–	–
Undergraduate	22.8	Undergraduate	20.4	–	–
Diploma	4.2	Diploma	12.3	–	–
Postgraduate	14.4	Postgraduate	21.7	–	–
Other qualification	2.2	Other qualification	1.3	–	–
<i>Employment</i>		<i>Employment</i>		<i>Employment</i>	
Full-time	49.5	Full-time	52.3	Full-time	39.7
Part-time	15.6	Part-time	16.3	Part-time	15.0
Unemployed	12.4	Unemployed	10.9	Unemployed	9.9
Retired	15.9	Retired	13.0	Retired	24.3
Student	2.4	Student	4.3	Student	3.7
Disabled	4.2	Disabled	3.2		
<i>Religion</i>		<i>Religion</i>		<i>Religion</i>	
Christian	55.0	Christian	71.7	Christian	48.2
Muslim	3.2	Muslim	1.8	Muslim	4.5
Jewish	0.6	Jewish	0.3	Jewish	2.3
Hindu	1.0	Hindu	0.7	Hindu	3.4
Buddhist	0.4	Buddhist	0.8	Buddhist	1.5
Atheist or agnostic	33.4	Atheist or agnostic	20.3	Atheist or agnostic	31.6
Other religion	6.3	Other religion	4.5	Other religion	7.4
Sikh	0.1	Sikh	–	Sikh	0.9

exceed expected cultural, social, or religious norms, and (5) presence of functional impairment. A copy of the IGQ is included in [Appendix 1](#).

Normal grieving periods

Participants were provided with the statement, “Consider the following situations and indicate how long you think an average person would grieve for before they come to terms with their loss” and asked to respond thinking about the death of an elderly parent, a parent during

childhood, a sibling, a child, and a close friend. The response categories were (1) within 6 months, (2) 6–12 months, (3) 1–2 years, (4) 2–3 years, (5) 3–5 years, (6) 6–10 years, and (7) more than 10 years.

Data analysis

To address the study’s first objective, one-way between-groups analysis of variance (ANOVA) tests with Scheffé post-hoc comparisons were used to

determine if PGD symptoms, and the proportion of people meeting symptom and impairment requirements for PGD, significantly differed across the seven time periods since bereavement. Effect sizes are reported using eta-squared (η^2) where values from .01 to .06 indicate a “small” effect, values from .06 to .13 indicate a “medium” effect, and values .14 and above indicate a “large” effect (Cohen, 1988). To address the study’s second objective, we report descriptive statistics (proportions, means, and standard deviations) for the five examples of bereavement. To address the study’s third objective, we report the proportion of people responding “Yes,” “No,” and “I don’t know” to the question of whether their grief reactions have persisted for longer than what would be expected in the culture or community. We report these figures for all those who are bereaved, for those with non-zero PGD symptoms, and for those meeting symptom and impairment requirements for PGD. To address the study’s fourth objective, we report the proportion of PGD “cases” with and without the time and culture requirements, and compared these proportions using a McNemar Z-test which is appropriate for paired-sample proportions. All analyses were performed separately for each sample and were analyzed using SPSS v28. There were no missing data.

Results

Figure 1 displays when people’s most distressing bereavement occurred. In each sample, the most common timeframe was “more than 10 years ago” (32.4%

to 40.6%), and the least common timeframes were “less than 6 months ago” (4.4% to 6.0%) and “6–12 months ago” (3.9% to 5.9%).

Objective 1: PGD across different periods following bereavement

Mean PGD symptoms significantly differed across the seven timeframes of bereavement in the Irish ($F(6, 1004) = 11.68, p < .001, \eta^2 = .07$ (95% CI = .04, .09)), UK ($F(6, 1005) = 16.96, p < .001, \eta^2 = .09$ (95% CI = .06, .12)) and Ontario ($F(6, 1163) = 9.46, p < .001, \eta^2 = .05$ (95% CI = .02, .06)) samples. The means are plotted in Figure 2, and as can be seen, there were similar trends in each sample with mean scores becoming gradually lower the longer ago the bereavement occurred. In the Irish and Ontario samples, PGD symptoms in those bereaved within the last 6 months were significantly higher than those bereaved 6 and 10 years ago and more than 10 years ago, while in the UK sample, PGD symptoms in those bereaved within the last 6 months were only significantly higher compared to those bereaved more than 10 years ago.

Proportions of people meeting symptom and impairment requirements for probable PGD in each sample are displayed in Figure 3. Proportions significantly differed across the seven bereavement timeframes in the Irish ($F(6, 1004) = 5.09, p < .001, \eta^2 = .03$ (95% CI = .01, .05)), UK ($F(6, 1005) = 8.15, p < .001, \eta^2 = .05$ (95% CI = .02, .07)), and Ontario ($F(6, 1163) = 5.70, p < .001, \eta^2 = .03$ (95% CI = .01, .05)) samples. The trends across the three samples

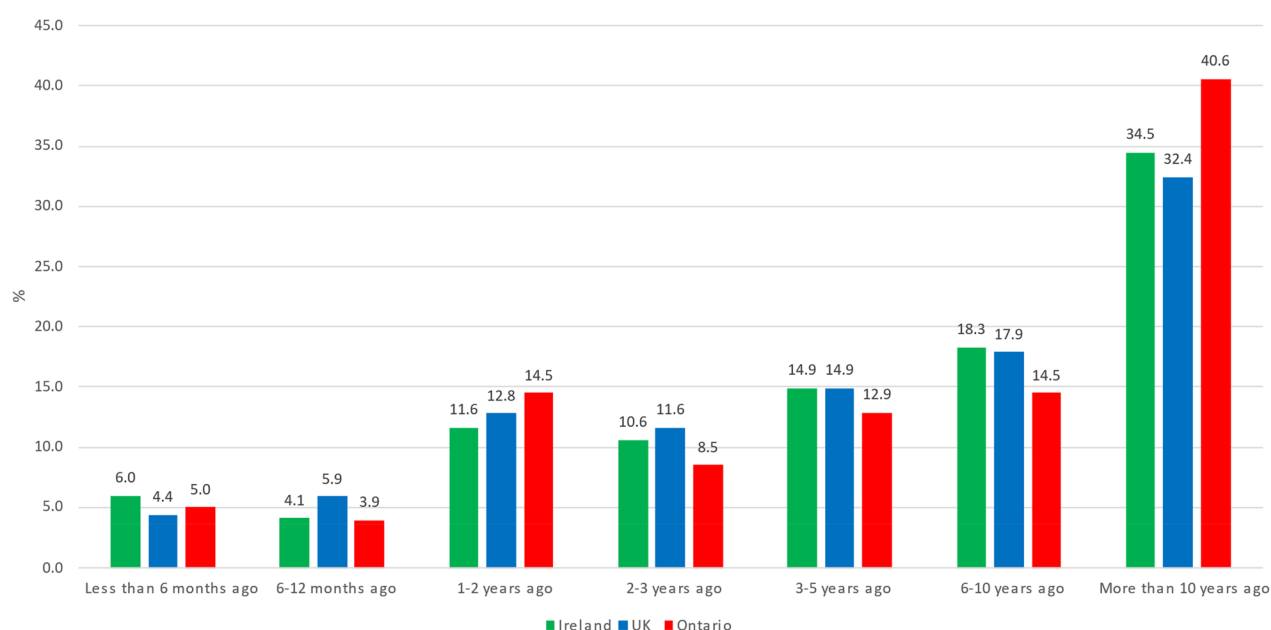


Figure 1. Proportion of people reporting how long ago their worst bereavement occurred.

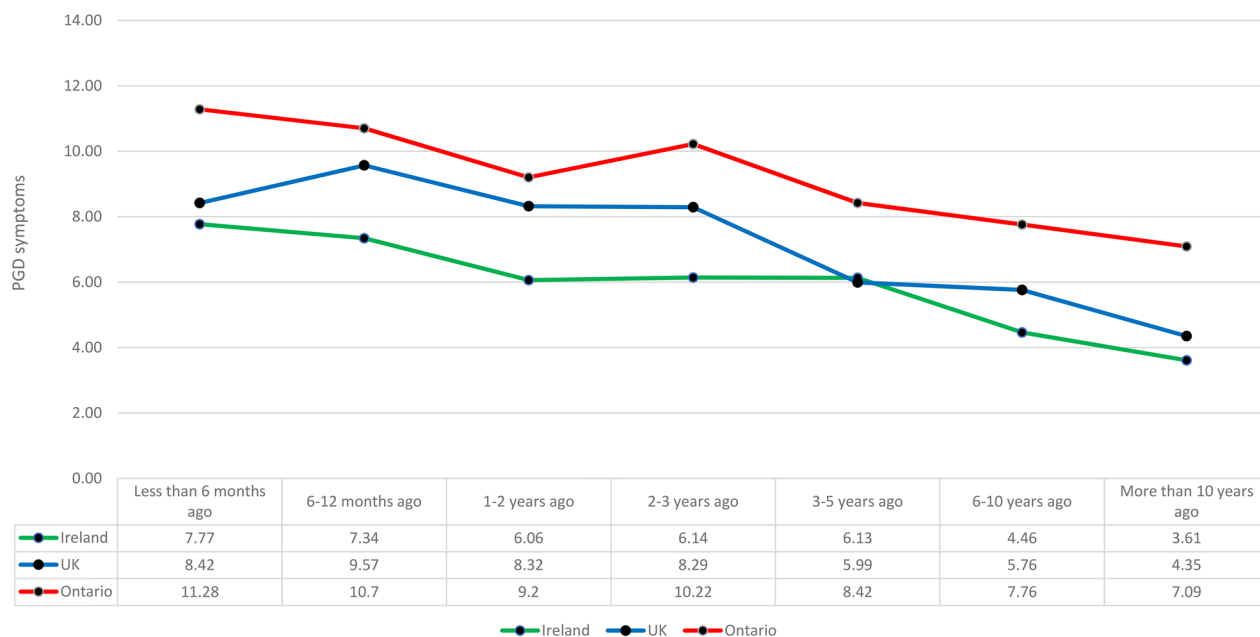


Figure 2. Mean Prolonged Grief Disorder symptoms among those bereaved at different points.

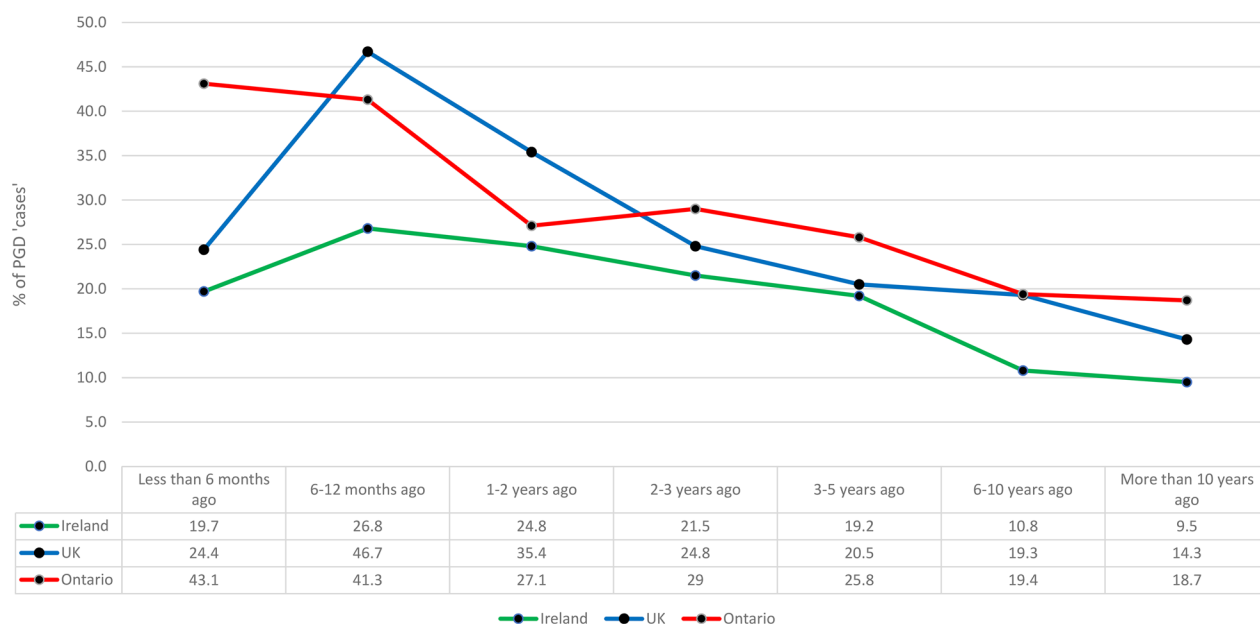


Figure 3. Proportion of Prolonged Grief Disorder “cases” among those bereaved at different points.

were quite different. In the Ontario sample, probable PGD rates in those bereaved within the last 6 months were significantly higher compared to those bereaved 6–10 years ago and more than 10 years ago. In the Irish and UK samples, there were no significant differences in probable PGD rates for those bereaved within the last 6 months to those bereaved at any other timeframe. See [Supplementary Materials 1A-1C](#) for correlations between the IGQ items and time since bereavement.

Objective 2: Grieving periods for different types of loss

As demonstrated in [Table 2](#), when asked how long it would take the average person to come to terms with losing different loved ones, “more than 10 years” was the modal response for the death of a parent during childhood, a sibling, and a child. “More than 10 years” was also the modal response for the death of a friend in the Irish and UK samples, while “1–2 years” was the modal response in the Ontario sample. In the

Table 2. Period of time people believe is necessary to come to terms with the loss of different loved ones.

	Elderly parent			Parent during childhood			Sibling			Child			Close Friend		
	UK	Ireland	Ontario	UK	Ireland	Ontario	UK	Ireland	Ontario	UK	Ireland	Ontario	UK	Ireland	Ontario
< 6 months	12.0%	11.5%	16.4%	5.1%	3.5%	5.1%	4.5%	3.0%	5.9%	2.5%	2.2%	4.1%	6.1%	5.1%	7.9%
6–12 months	20.0%	17.9%	20.1%	5.8%	5.4%	8.6%	7.2%	6.5%	8.1%	3.0%	2.1%	2.7%	10.8%	8.3%	14.1%
1–2 years	18.6%	21.5%	20.9%	12.8%	12.2%	15.6%	12.8%	10.0%	18.0%	6.3%	3.5%	7.0%	15.7%	14.6%	20.2%
2–3 years	13.5%	14.2%	11.8%	11.9%	13.3%	11.1%	15.3%	12.6%	14.5%	7.8%	6.2%	9.0%	16.5%	17.6%	15.9%
3–5 years	9.7%	12.1%	9.9%	15.0%	12.2%	13.7%	14.5%	19.7%	16.1%	9.6%	6.5%	11.2%	16.9%	20.0%	17.1%
6–10 years	5.6%	6.2%	4.7%	8.9%	12.1%	11.2%	9.9%	11.4%	9.1%	6.4%	9.4%	8.6%	10.9%	12.8%	8.7%
>10 years	20.7%	16.6%	16.3%	40.4%	41.4%	34.6%	35.7%	36.9%	28.3%	64.4%	70.1%	57.4%	23.1%	21.6%	16.2%
Mean	3.89	3.83	3.58	5.14	5.27	4.92	5.00	5.21	4.67	5.96	6.22	5.76	4.52	4.64	4.11
SD	2.06	1.95	2.02	1.92	1.84	1.96	1.89	1.77	1.91	1.65	1.47	1.75	1.89	1.79	1.86

Note: Modal responses are in **bold**.

case of the death of an elderly parent, the modal response in the Irish and Ontario samples was “1–2 years,” and “more than 10 years” in the UK sample. Thus, in no case was “within 6 months” selected as the most common response. In fact, except for the death of an elderly parent, the least frequently cited timeframe was “within 6 months.” Notably, the relatively large standard deviations for each bereavement type highlights the variability in what people perceive to be the time needed for an average person to come to terms with a bereavement.

Objective 3: Exceeding cultural norms

In the Irish sample, when asked if their grief reactions were worse than what would be expected in their culture or community, 62.0% ($n=627$) of people said “No,” 16.6% ($n=168$) said “Yes,” and 21.4% ($n=216$) said “I don’t know.” Among those with non-zero PGD symptoms (75.1% (95% CI = 72.4%, 77.8%), $n=759$), 53.6% ($n=407$) said “No,” 21.7% ($n=165$) said “Yes,” and 24.6% ($n=187$) said “I don’t know.” Focusing only on those meeting symptom and impairment requirements for PGD (15.5% (95% CI = 13.3%, 17.8%), $n=157$), 24.8% ($n=39$) said “No,” 49.7% ($n=78$) said “Yes,” and 25.5% ($n=40$) said “I don’t know.”

In the UK sample, 58.3% ($n=590$) of people answered “No,” 21.0% ($n=213$) answered “Yes,” and 20.7% ($n=209$) answered “I don’t know” to the same question. Among those with non-zero PGD symptoms (76.9% (95% CI = 74.3%, 79.5%), $n=778$), 49.7% ($n=387$) said “No,” 26.9% ($n=209$) said “Yes,” and 23.4% ($n=182$) said “I don’t know.” In those meeting symptom and impairment requirements for PGD (22.4% (95% CI = 19.9%, 25.0%), $n=227$), 24.2% ($n=55$) said “No,” 55.1% ($n=125$) said “Yes,” and 20.7% ($n=47$) said “I don’t know.”

In the Ontario sample, 48.2% ($n=564$) answered “No,” 26.6% ($n=311$) answered “Yes,” and 25.2% ($n=295$) answered “I don’t know.” Among those with non-zero PGD symptoms (90.1%, (95% CI = 88.4%,

92.0%), $n=1054$), 44.7% ($n=471$) said “No,” 28.8% ($n=304$) said “Yes,” and 26.5% ($n=279$) said “I don’t know.” Among those meeting symptom and impairment requirements for PGD (23.9%, $n=280$; 95% CI = 21.5%, 26.4%), 16.1% ($n=45$) said “No,” 57.9% ($n=162$) said “Yes,” and 26.1% ($n=73$) said “I don’t know.”

Thus, findings were similar across the three samples in that a substantial minority of bereaved people (20–26%) could not say if their grief reactions were or were not worse than what would be expected in their culture or community.

Objective 4: Effect of the time and culture requirements on PGD “cases”

Significantly fewer people screened positive for PGD when the time and culture requirements were used compared to when they were not used in the Irish (10.7% vs 15.5%, McNemar’s $Z=7.00$, $p < .001$), UK (16.2% vs 22.4%, McNemar’s $Z=7.94$, $p < .001$), and Ontario (18.5% vs. 23.9%, McNemar’s $Z=7.94$, $p < .001$) samples.

Discussion

The purpose of this study was to examine the merits of the related six-month time criterion and the exceeding cultural norms criterion in the *ICD-11* diagnostic description of PGD. Using cross-sectional data from three culturally distinct general population samples of bereaved adults, we found no evidence to support the assumption that PGD symptoms are “typical” or normative in the immediate aftermath of a bereavement nor that there is a natural recovery point at six months (or later) post-bereavement. Symptoms of PGD were not markedly higher in those bereaved within the last six months compared to those bereaved longer ago, and it was generally only those bereaved more than six or ten years ago that reported significantly lower symptom levels, and even then, the differences were small.

Similar findings were observed at the probable diagnosis level. In the Irish and UK samples, approximately 20% and 24% of people bereaved within the last six months screened positive for PGD, with the figure being quite a bit higher in the Ontario sample where 43% screened positive. Moreover, in none of the samples did these figures significantly drop in the next bereavement timeframe (6–12 months ago), and, in fact, it significantly increased in the UK sample. In the UK sample, the proportion of people bereaved 6–12 months ago that screened positive for PGD was nearly twice as high as for people bereaved within the last six months. The key result that bears on the *ICD-11*'s six-month time criterion is that in the UK and Irish samples, people who experienced the death of a loved one in the last six months were no more likely to screen positive for PGD than those who lost a loved one at any other time in the past, while in the Ontario sample, those people who experienced their bereavement in the last six months were no more likely to screen positive for PGD than those bereaved in the last five years. Thus, the current study provides no evidence that the six-month time criterion is necessary to avoid mis-diagnosing normative grief reactions as being pathological (Reed et al., 2022).

The findings from the UK sample where the proportion of people bereaved 6–12 months ago was nearly twice as high as those bereaved within the last six months is particularly relevant to *DSM-5-TR* PGD (American Psychiatric Association [APA], 2022) which includes an even more stringent time criterion of 12-months. The evidence from this study, and from other longitudinal studies of grief (Bonanno & Malgaroli, 2020; Djelantik et al., 2022; Lundorff et al., 2020; Nam, 2015), demonstrates that grief symptoms are pathological by their nature, not by virtue of their chronicity. Consequently, the six-month time criterion (and the 12-month time criterion in *DSM-5-TR* based on findings from the UK sample) is unlikely to assist in avoiding type 1 (false-positive) diagnostic errors, but it could very likely increase the number of type 2 (false-negative) diagnostic errors.

When we asked people in each sample how long they believed it would take the average person to come to terms with losing different loved ones, in no situation was “within 6 months” the most likely timeframe to be selected. In fact, in almost all cases “within 6 months” was the least likely timeframe to be selected, while “more than 10 years” was the most likely timeframe to be selected. Furthermore, although the modal response was typically the same for each type of loss in each sample (i.e., “more than 10 years”), there was considerable variation among

respondents in what they perceived to be the normal grieving period, both for specific types of loss (i.e., a child, a friend) and across types of loss. The *ICD-11* description of PGD not only states that six months or more is an atypical grieving period, but by also excluding any conditions on the time criterion according to relationship with the deceased, it implies that this is the typical grieving period irrespective of one's relationship to the deceased. The latter assumption is contradicted by a great deal of evidence showing that one's relationship to the deceased is a major risk factor for more intense grief following bereavement (Doering et al., 2022; Lobb et al., 2010; Shevlin et al., 2023), and now current findings indicate that across culturally distinct populations, only a tiny fraction of people believe the normative or typical time to come to terms with a loss to be within six months. In the absence of any empirical evidence to support the proposition that most people come to terms with bereavement within six months, the finding that vast majorities of the public reject this proposition could be viewed as an impediment to effective public communication and implementation of the PGD diagnosis in clinical practice. However, it should be noted that we are solely examining people's perceptions about how long it takes to *come to terms* with a loss rather than how long it would be considered to experience *intense and debilitating grief*. This means that our conclusions do not directly map onto the *ICD-11* specification of the time criterion, and thus further research will be required. Nevertheless, findings indicates that the time criterion as it currently stands may be superfluous.

Turning attention to the cultural criterion, regardless of whether we focused on all bereaved people, only those bereaved people who were symptomatic, or only those that met symptom and impairment requirements for PGD, a substantial minority (~20–27%) said that they did not know if their grief responses exceeded norms and expectations in their own culture or community. The *ICD-11* stipulate that grief reactions *must* exceed cultural, social, or religious norms, so if approximately one-fifth to one-quarter of people meeting all other diagnostic requirements cannot provide an unequivocal answer to this issue, then it falls to the clinician to make this determination. This means that diagnosis of PGD for many people will rest on their clinician (a) knowing what the grieving norms are in every possible cultural, religious, and social context, and (b) being able to judge with satisfactory reliability and validity if the person's reactions exceed these norms. This places clinicians in an almost impossible position, particularly given the multicultural nature of society which

makes the application of such requirements even more difficult. Strict adherence to the diagnostic requirements might require a clinician not to apply a diagnosis to someone who meets all other diagnostic requirements, or the clinician may choose to ignore this criterion and apply the diagnosis. We contend that the inclusion of this criterion undermines the clinical utility of the diagnosis. Like the arguments outlined in a recent study (Redican et al., 2024), this criterion will be extremely difficult to implement and might increase type 2 (false-negative) diagnostic errors. Whatever one may say about this criterion, it is hard to argue that its inclusion maximizes the clinical utility of the diagnosis.

Regarding the study's final objective, and as hypothesized, significantly fewer people in each sample screened positive for PGD when the full *ICD-11* diagnostic requirements were used compared to when the time and culture requirements were excluded. These differences were considerable. When used, probable PGD rates dropped, in relative terms, by 25.4% in the Ontario sample, 32.1% in the UK sample, and 36.6% in the Irish sample. It must be noted that in this study – as in other studies (Hyland et al., 2024) – people who said that they did not know if their symptoms exceeded cultural norms were *not* excluded from meeting diagnostic requirements. This is a debatable decision, but the key point is that if these people had been excluded, the relative drop in diagnostic status would have been even larger. Thus, these requirements do seem to be having the intended effect of reducing the number of people that qualify for a diagnosis of PGD. But given our findings that probable PGD rates are not significantly higher in the immediate aftermath of bereavement, and that many people cannot say if their grief responses exceed cultural norms, one may reasonably worry that these requirements are preventing people who are suffering from qualifying for a diagnosis.

These findings should be interpreted in light of several limitations. First, because a non-probability sampling method was used, vulnerable members of society such as those hospitalized, incarcerated, or homeless were not contactable and this may limit the generalizability of the findings. Second, the cross-sectional design of the study meant it was not possible to model trajectories of grief symptoms and probable PGD rates over time. Future studies using longitudinal data will be required to explore this matter. Third, although the three samples were drawn from relatively distinct cultural contexts, all three share some things in common (English-speaking, western, individualistic, and historically

Christian-influenced cultures). It would be useful to replicate these findings in other cultural contexts. Fourth, the small effect sizes might indicate that several associations were statistically significant due to the large sample sizes, and thus, replication is required across different samples. Fifth, the ambiguous wording of the item measuring normative grieving periods makes it impossible to ascertain whether participants were responding in terms of the time it takes for an intense and debilitating grief that significantly impairs functioning to abate. This should be taken into consideration when interpreting our findings surrounding the time criterion. Finally, the self-report nature of the cultural deviation criterion may have influenced findings. While participants were provided with a response option of “*I don't know*,” it will only be through additional research conducted using structured clinical interviews and qualitative methodology where the clinical utility of the cultural criterion can be conclusively determined.

In conclusion, our findings call into question the validity and utility of the duration and cultural requirements in *ICD-11* PGD. The central premise of PGD, as currently described in *ICD-11*, suggests that symptoms are not inherently pathological but become clinically significant due to their persistence over time, particularly in relation to cultural expectations about grief duration (Maciejewski et al., 2016). However, findings from the present study do not fully support the view. As previously highlighted, future studies using longitudinal data as well as clinical data will be required to further investigate this matter. Nevertheless, current and past findings indicate that most bereaved people, irrespective of culture, do not report high levels of grief in the aftermath of a bereavement, and for those who do, there is no “typical” recovery point. As with any other psychiatric disorder, the experiences that define PGD appear to be distressing by their nature, irrespective of their chronicity or the cultural context in which they occur.

The current situation means that an individual that has experienced a bereavement and is suffering weeks or months afterwards can be diagnosed with virtually any psychiatric disorder except for the one diagnosis that is related to grief. Removing the duration and cultural requirements could be advantageous because it would simplify the diagnosis by focusing on the symptoms, and the impairments they cause, which are the key targets for therapeutic interventions (Bryant et al., 2014; Rosner et al., 2014; Szuhany et al., 2021). Moreover, since the evidence shows that PGD symptoms during the early months of bereavement are predictive of subsequent PGD diagnosis

(Boelen & Lenferink, 2022), early interventions would become available that could prevent chronic problems from developing. It should be noted, however, that there is some evidence to indicate that certain early interventions may be ineffective or even harmful if delivered too soon after the loss (Schut et al., 2001). Thus, fundamental conclusions about the clinical utility of the duration requirements in the PGD diagnosis (such as the removal of this criterion altogether) might therefore require a study that explores whether PGD treatment responses are influenced by the time since the loss. Although the findings from this study question the definition and implementation of the time and culture requirements, as well as whether they are truly necessary, we are not suggesting that these requirements be discarded altogether. A diagnostic description could come with guidance that clinicians should consider the recency of bereavement and the patient's cultural, social, or religious context when considering the appropriateness of diagnosis. Considering that these factors were not found to be relevant for a PGD diagnosis in this study, a question remains as to what are the factors that distinguish normal from pathological grief responses. There is clearly a need for further research in the field exploring the role of inter- and intra-individual factors that determine grief responses across different cultures.

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Data availability statement

Neither the data nor the materials have been made available on a permanent third-party archive; requests for the data or materials should be sent via email to authors (m.shevlin@ulster.ac.uk or Philip.Hyland@mu.ie).

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Appendix 1. The International Grief Questionnaire (IGQ)

The International Grief Questionnaire

During your life have you known anyone who has died who you were very close to (e.g., a partner, parent, child, close friend)?

- ☐ Yes
- ☐ No

How long ago did this person die?

- ☐ Within the last 6 months
- ☐ 6 months to a year ago
- ☐ 1–2 years ago
- ☐ 2–3 years ago
- ☐ 3–5 years ago
- ☐ 6–10 years ago
- ☐ More than 10 years ago

Below are a number of problems that people sometimes report following the death of a person close to them. Using the scale below, please indicate how much you have been bothered by each of the following over the **past week**.

Not at all	A little bit	Moderately	Quite a bit	Extremely		
1	2	3	4	5		
1. Yearning for the deceased <i>almost every day?</i>		1	2	3	4	5
2. Thinking too much about the deceased <i>almost every day?</i>		1	2	3	4	5
3. Feeling guilty or angry about my loss.		1	2	3	4	5
4. Having trouble accepting the death of my loved one.		1	2	3	4	5
5. Feeling sad or emotionally numb.		1	2	3	4	5

Have these experiences caused problems in personal, family, social, educational, occupational, or other important areas of your life?

- ☐ Yes
- ☐ No

Do you consider your grief to be worse (more intense and/or of longer duration) than what would be normally expected in your community or culture?

- ☐ Yes
- ☐ No