Reviewer's report

Title: Posttraumatic Stress Disorder and Prolonged Grief in Refugees Exposed to Trauma and Loss

Version: 2  Date: 4 February 2014

Reviewer: Nadja Jacob

Reviewer's report:

Major Compulsory Revisions:

Methods:

Page 6: Instrument: blind back-translation? Validation of the questionnaires? If not, this needs to be included into the limitations. If it was done, it needs to be included in the methods.

Measures: definition of all the presented scales but at least the range of the symptom-score and of the event-score (how many trauma exposure items?)

How long did the interviews take? Where were they done? On the phone/in person? Did you administer all instruments as interview?

How did you contact the participants? How many refused and how many you were not able to contact?

What was the qualification of the research assistants? Did they have training/experience to administer the interview and on the clinical concepts?

What inclusion criteria did you use for the PTSD and PGD group: score (cut-off?) or the diagnosis (according to DSM or ICD)?

Are the concepts “loss of culture and support” and “adaptation” distinct concepts – are they validated? As you use it as argument for the distinctiveness between the concepts of PGD and PTSD information about the concepts and the validity should be given.

Data analysis:

I think it would be essential to do the statistical analysis in a way not only to demonstrate a distinct pattern from PTSD but also to include the distinction of PGD and MD (and anxiety disorders) as data in the past have been highly controversial; e.g. (Boelen & Prigerson, 2007; Boelen & van den Bout; 2005; Bonanno et al., 2007; Hogan, Worden, & Schmidt, 2004; Kim & Jacobs, 1991; Mehlem et al., 2004; Melhem et al., 2007; Momartin et al., 2004).

Further you have extremely high co-morbidity. Especially Schaal, 2010 showed the almost complete overlap between diagnostic symptom clusters.
Discussion:

The controversy of the mixed previous findings about the PGD concept is missing completely e.g. Schaal 2010, Boelen & Prigerson, 2007; Boelen & van den Bout; 2005; Boelen, van den Bout & de Keijser, 2003; Boelen & van den Bout; 2005; Chen, Bierhals, Prigerson, Kasl, Mazure, & Jacobs, 1999; Prigerson et al., 1996) (Pivar & Field, 2004).

To evaluate the clinical relevance of the concept of PGD it would be essential to distinguish it from depression (as well as anxiety) – I think it is impossible to state the clinical relevance as the comparison to other similar (perhaps identical?) clinical concepts is missing.

In the regression analysis you further show that the trauma exposure is the best (and significant) predictor for all your 3 clinical classes – what is the indication for a different clinical intervention?

Minor Essential Revisions:

Discussion:

What is you explanation, that traumatic loss is a predictor for PTSD/PGD but not for PGD? There was more research that needs to be included.

Why is age so important as predictor for clinical problems? Older = more traumatic events? Or is there no flexibility for adaptation in the new culture?

I am very surprised that asylum status as well as socioeconomic status are not relevant in your study for mental health status. There are other findings in the literature.

Discretionary Revisions:

Page 5: PMLDC: introduction of the abbreviation (only once used in the document)

Page 11: missing space before Reference 25 & 9

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests:

I declare that I have no competing interests