Both DSM-IV and ICD-10 intentionally exclude grief reactions as possible psychiatric disorders, because grief is a normal response to bereavement, and there has traditionally been a reluctance to label any form of bereavement-related response with a psychiatric diagnosis. In DSM-5, due to be released in 2013, there has been a marked shift in the conceptualisation of bereavement response with two important changes that have stimulated enormous controversy (see www.dsm5.org).

Medicalising bereavement?

In DSM-IV clinicians are cautioned against diagnosing depression after bereavement lest they describe initial depressive responses to bereavement as a mental disorder; DSM-IV advises psychiatrists to consider a depression diagnosis only if the state persists for at least 2 months following the death and is characterised by signs of more serious depression, such as suicidal ideation or psychomotor retardation. It is proposed that in DSM-5 this qualification should be removed, partly because of evidence that bereavement-related depression is comparable to depression following other life stressors. Proponents of the change argue that excluding bereavement-related depression might prevent depressed bereaved people from receiving care. Opponents of this change posit that removing the bereavement exclusion potentially medicalises acute grief, and might lead to unnecessary antidepressant treatment of normal distress. Recent data indicate that depression in the context of bereavement tends to be less severe and less likely to return than depression unrelated to bereavement, suggesting that it may not be comparable to other forms of depression – and providing support for caution in prescribing antidepressants following bereavement. The extent to which depression following bereavement is comparable to depression after life stressors has yet to be adequately resolved. At present there are insufficient empirical data to shape diagnostic decisions addressing the distinctions between expected (and transient) and complicated (and persistent) depression after bereavement. In the absence of evidence, the question facing both diagnostic systems is how to provide clinicians with cautionary advice to avoid pathologising normal depressive responses after bereavement that nonetheless recognises the need for management of marked depression. It is worth noting that the exclusionary note does not explicitly prevent a depression diagnosis, but urges clinicians to consider the possibility that a normal bereavement response may explain the depressive presentation. The question remains: do we have sufficient data to warrant not reminding clinicians to think carefully about diagnosing depression in the acute phase following bereavement?
emotional pain cause dysfunction is not present in bereavement-related depression. Second, there is mounting evidence that the proportion of bereaved people who have severe grief reactions that do not abate over time also experience marked psychological, social, health or occupational impairment. There is strong evidence that people who meet the criteria for prolonged grief reactions are more likely to experience other psychological problems (e.g. depression, suicidality, substance misuse), poor health behaviours (e.g. increased tobacco use), medical disorders (e.g. high blood pressure, elevated cancer rates, increased cardiovascular disorder) and functional disability. Third, the construct of prolonged grief that involves persistent yearning has been demonstrated across a wide range of cultures, including non-Western settings, as well as across the life span. Fourth, there are distinctive predictors, neural dysfunctions and cognitive patterns associated with prolonged grief. Fifth, whereas bereavement-related depression responds to antidepressant interventions, grief reactions do not. Sixth, treatments specifically targeted towards the core symptoms of prolonged grief are effective in alleviating the condition, and more effective than treatment that targets depression.

This accumulating evidence appears to provide support for a diagnosis that describes the minority of bereaved people with persistent grief-related impairment. The argument that it is inappropriate to describe any grief reaction as a psychiatric disorder ignores the evidence that there is a constellation of symptoms that persist in a substantial minority of bereaved people which contribute to significant psychological, medical and social problems, and which can be treated with evidence-based interventions. On the basis of evidence that up to 15% of bereaved people experience serious grief, there are over a million new cases of prolonged grief in the USA each year, representing a significant public health issue. Introducing a diagnosis that could facilitate improvements in healthcare for the proportion of the bereaved population who endure prolonged grief.

The need for evidence

The current proposals need to be weighed carefully. There are valid arguments why grief reactions within the normal time frame of mourning should not be labelled as a psychiatric disorder; there is justified concern about unnecessary treatment and stigmatisation of non-pathological responses. In terms of depression, it is important to find the balance between identifying bereaved people who require treatment and overlabelling transient grief responses; the current bereavement exclusion criteria for diagnosis of depression go some way towards achieving this end. The decision to remove this cautionary note might unnecessarily shift this balance towards overdiagnosis of acute bereavement distress. The problem facing clinicians is that we lack the required data to justify any diagnostic demarcation between transient and persistent depression following bereavement. In contrast to depression, the proposal to describe prolonged grief reactions as those persisting after 12 months is based on a growing evidence base that minimises the risk of false positive diagnoses and permits identification of bereaved people who are experiencing marked impairment and can benefit from specific evidence-based treatment. This new diagnosis implies neither that grief is ever ‘resolved’ (in the sense that the bereaved person no longer feels distress over the loss) nor that there is a uniform manner in which people manage grief. Instead, it identifies people who display persistent and impairing distress that can be eased with treatment.

As the profession debates these new diagnostic proposals, it is critical that evidence rather than emotive arguments should shape our decisions. Adopting an ideological position that no grief reaction can be described as a psychiatric disorder will result in many bereaved people being denied treatment that could alleviate their distress and lead to an array of better health and social outcomes. A balanced debate about these diagnostic developments that adheres to the current evidence will, it is hoped, enhance better management of the marked psychological and health costs of persistent grief while maintaining a healthy recognition of the distinction between normal and prolonged forms of severe depression and grief in the wake of bereavement.

**References**

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