BJPsych | The British Journal of Psychiatry (2012)
201, 9–10. doi: 10.1192/bjp.bp.111.102889

Reappraisal

Grief as a psychiatric disorder

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Summary
The revisions DSM-5 and ICD-11 are attempting to describe psychopathological reactions to bereavement. The delineation between depressive disorder and normal bereavement-related depressed state lacks sufficient data to guide diagnostic development. In contrast, there is strong evidence for a diagnosis of prolonged grief that is distinguished from depression and involves marked impairment.

Declaration of interest
The author serves on the DSM-5 PTSD/Trauma/Dissociation Work Group and the ICD-11 Working Group on the Classification of Stress-Related Disorders.

Both DSM-IV and ICD-10 intentionally exclude grief reactions as possible psychiatric disorders,[1,2] 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.[3,4] Proponents of the change argue that excluding bereavement-related depression might prevent depressed bereaved people from receiving care.[5] Opponents of this change posit that removing the bereavement exclusion potentially medicalises acute grief, and might lead to unnecessary antidepressant treatment of normal distress.[6,7] 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,[8] 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.[6] 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?

New diagnosis

The other major change in DSM-5 is the proposed 'adjustment disorder related to bereavement'. This represents the first diagnosis to specifically recognise a form of grief as a psychiatric disorder, and is defined as a severe grief reaction that persists for at least 12 months after the death of a close relative or friend, in which the individual experiences intense yearning, emotional pain or preoccupation with the death on most days. This response may be accompanied by difficulty accepting the death, anger over the loss, a diminished sense of identity, feeling that life is empty and problems in engaging in new relationships or activities.[9] Previous studies estimate that 10–15% of bereaved people may experience this condition.[10,11] Several studies suggest that most people report remission from the acute distress by 6–12 months following the death, and that those who experience severe grief reactions beyond this time are likely to continue to experience intense grief and associated problems.[11,12]

The case against

There have been strong objections to this new diagnosis. First, it is argued that human grief is a ubiquitous condition insofar as death and loss are part of being human; accordingly, the emotional pain that is felt following bereavement is perceived as understandable and should not be medicalised. Second, grief is managed differently across cultures and thus it is not possible for a single diagnostic system to dictate a uniform standard of grieving that applies to all cultures. Third, grief is unlike most other psychological responses in that it is closely interwoven into religious practices, and it is inappropriate for psychiatry to infringe on these rituals. Fourth, grief is adequately described by existing anxiety and depression reactions and there is no need to identify it as a distinct construct.

Six arguments in favour

In contrast to these views, several major justifications have been put forward for introducing a specific diagnosis to describe persistent and problematic grief reactions. First, factor analytic studies have shown that the core aspects of the grief response (e.g. yearning for the deceased) are distinct from anxiety and depression, and they contribute uniquely to the impairment suffered by these individuals.[10] The core difference between grief and depression is the presence of yearning in prolonged grief; persistently missing the person and having the associated

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.[10,13] 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.[13,14] Fourth, there are distinctive predictors, neural dysfunctions and cognitive patterns associated with prolonged grief.[11] Fifth, whereas bereavement-related depression responds to antidepressant interventions, grief reactions do not.[10] 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.[15]

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 identification and treatment of these people might lead to marked 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.

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First received 13 Sep 2011, final revision 18 Dec 2011, accepted 15 Mar 2012

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BJP 2012, 201:9-10.
Access the most recent version at DOI: 10.1192/bjp.bp.111.102889